DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3EXP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00276

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245055**
2.STATE VENDOR OR MEDICAID NO.
(L2) **202742900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER METHODIST HEALTH CENTER**
(L4) **3737 BRYANT AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/05/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
02/28

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **330** (L18)

13.Total Certified Beds **330** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	308	22		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NEII 05/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/04/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/21/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245055

June 4, 2015

Ms. Brooke Viegut, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

Dear Ms. Viegut:

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 and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective April 22, 2015 the above facility is certified for:

308	Skilled Nursing Facility/Nursing Facility Beds
22	Nursing Facility I Beds

Your facility's Medicare approved area consists of all 308 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 Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

Ms. Brooke Viegut, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

RE: Project Number S5055025

Dear Ms. Viegut:

On April 3, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on March 13, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 5, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on March 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 22, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard extended survey, completed on March 13, 2015, effective April 22, 2015 and therefore remedies outlined in our letter to you dated April 3, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245055	A. Building B. Wing	5/5/2015

Name of Facility	Street Address, City, State, Zip Code
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **04/22/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **05/05/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	Correction Completed **05/05/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/05/2015**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/22/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/05/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/05/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/05/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/kfd	05/06/2015	30921	05/05/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/13/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245055	A. Building / B. Wing: 01 - BUILDING 01	4/24/2015

Name of Facility	Street Address, City, State, Zip Code
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	04/22/2015	ID Prefix Reg. # NFPA 101 LSC K0029	04/22/2015	ID Prefix Reg. # NFPA 101 LSC K0038	04/22/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	05/06/2015	28120	04/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/16/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3EXP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00276

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245055**
2.STATE VENDOR OR MEDICAID NO.
(L2) **202742900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER METHODIST HEALTH CENTER**
(L4) **3737 BRYANT AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/13/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
02/28

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **330** (L18)

13.Total Certified Beds **330** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: X * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	308	22		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
An extended survey was completed 3/13/15, with Substandard Quality of Care (SQC) found at tag F0226 (Develop/Implement Abuse/Neglect, Etc Policies)

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR Social Work Specialist 04/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/21/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 3, 2015

Ms. Brooke Viegut, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

RE: Project Number S5055025

Dear Ms. Viegut:

On March 13, 2015, an extended 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate

jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970
Gayle.Lantto@state.mn.us
Telephone: (651) 201-3794 Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 22, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 22, 2015 the following remedy will be imposed:

- Per instance civil money penalty (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Walker Methodist Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective March 13, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director

330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will

recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 June 13, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 13, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted at the time of the re-certification survey.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the recertification survey results were available for review. This had the potential to affect all	F 167	*The most recent survey results have been posted in a place readily accessible to residents and visitors. *The most recent survey results will be	4/22/15

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

Electronically Signed | 04/11/2015

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F 167	Continued From page 1 residents residing in the facility and their visitors. Findings include: During the initial tour on 3/9/15, at 8:36 a.m. a binder was observed at the reception desk entitled "Survey Results" however when reviewed, the survey results from the most recent recertification survey were missing. The administrative assistant verified at the time of the observation that the document was missing. At 9:33 a.m. when asked where the survey results could be located, the administrative assistant stated, "The administrator is working on the book [survey results binder]." At 9:45 a.m. the administrator reported, "I just printed another copy off of last year's survey results. I have been printing one off each month, as someone keeps taking the copy of the survey results out of the binder." However, the facility did not ensure a system for maintaining a copy of the survey results was available. On 3/13/15, a policy related to survey posting was requested, but was not provided.	F 167	updated as necessary and remain posted in a place readily accessible to residents and visitors. *All staff have been educated on the requirement to post the most recent survey results in a place readily accessible to residents and visitors. *Monitoring to ensure compliance will be conducted by the Administrator or designee through daily audits of the survey result postings. *The facility QAPI committee will review the status of the survey results posting audits quarterly for further recommendations.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 176	*R88 has passed away since the survey	4/22/15

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F 176	Continued From page 2 review, the facility failed to ensure the safe practice of self-administration of medications for 1 of 1 resident (R88) who was observed during random observations to self-administer a nebulizer treatment. Findings include: R88 was was observed during a random observation on 3/13/15 at 9:37 a.m., to be self-administering a nebulizer treatment. The resident was observed to be awake with a nebulizer face mask in place, with the nebulizer machine running. Licensed practical nurse (LPN)-A who was observed to enter the resident's room at 9:47 a.m. and was observed to turn the nebulizer off, remove the face mask, and rinse the mask and chamber. During an interview with R88 on 3/13/15 at 9:51 a.m. the resident reported, "They normally put the machine on me and leave. They don't stay here with me. Sometimes when it is done, I will take it off because I don't need anyone here for this machine." When interviewed at 9:56 a.m. on 3/13/15, LPN-A acknowledged R88 should not have been left to self-administer the medication and stated, "I should have stayed in the room with her." During an interview with registered nurse (RN)-A on 3/13/15, at 10:00 a.m. the RN stated, "My expectation is the nurse should stay with her during the nebulizer treatment because of her current disease process." RN-A said they would complete an assessment for R88 if needed. R88's current physician's order dated 2/26/15,	F 176	date. *All residents who choose to self-administer medications have been assessed by the IDT for ability to carry out this responsibility. Residents who are assessed by the IDT as unable to carry out this responsibility will be monitored during administration of medications per facility policy and procedure. *All licensed nursing staff have been educated on the facility self-administration of medication policy and procedures, including the Self-Administration Assessment form. *Monitoring to ensure compliance will be conducted by the DON or designee through random observation audits to ensure medication is being administered per policy and procedure and assessment form results. *The facility QAPI committee will review the status of resident self-administration audits quarterly for further recommendations.	

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F 176	Continued From page 3 directed staff to administer Ipratropium solution 0.02 % inhaler per nebulizer three times daily for chronic obstructive pulmonary disease. A 9/19/14, Self-Administration Assessment Tool completed for R88 indicated, "The resident is assessed unable to safely self-administer medications for the following reasons; unable to safely read and administer meds secondary to mobility." In addition, R88's Self-Administration of Medications Sheet dated 9/19/14 included, "I have been informed of my right to self-administer drugs and I choose to defer this responsibility to the facility." Interventions on R88's care plan dated 10/1/14 included, "Administer medications per orders, and monitor for response." The quarterly Minimum Data Set (MDS) dated 12/27/14, indicated the resident had a diagnosis of chronic airway obstruction, and that the resident had moderately impaired cognition and a diagnosis of dementia. The facility Self-Administration of Medications policy revised 9/3/13 included; "Policy: Self-administration of medications and resident room medication storage is permitted for residents who have been assessed to be capable to self-administer medications, if desired appropriate in judgment of the facility's interdisciplinary team (IDT) and up on written order of the physician. Procedure: 3. Process for self-Administration of medications: B. The physician's order must be signed and dated prior to self-administration and resident's room storage."	F 176		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		4/22/15

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F 225 SS=E	Continued From page 4 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report to the administrator and/or designated State agency (SA) potential neglect of supervision after significant injury for 2 of 2 residents (R622, R34); failed to report bruising of unknown cause for 1 of 4 residents (R148) reviewed for non-pressure related skin problems; and failed to report an allegation of potential abuse for 1 of 4 residents (R16) whose reports were reviewed for abuse prohibition. Findings include: R622 sustained a fracture after an unwitnessed fall at the facility that was not immediately reported to the SA for potential neglect of supervision. R622's history and physical dated 2/26/17, noted the resident fell at home and sustained a lumbar compression fracture. After hospitalization from 2/17/15 to 2/27/15, the resident was admitted to the nursing home with acute delirium (a quick, severe, and short lived mental disorder), lumbar vertebral fracture, ataxia (abnormal gait), with a history of falls noted. R622's 2/27/15, Safety Risk Assessment noted the resident did not display behavioral problems, but had a history of falls and indicated a floor mat would be used. An initial care plan also dated 2/27/15, noted a potential/actual alteration in safety, falls related to weakness, balance impairment, cognitive impairment, poor judgment, impulsiveness, agitation, as well as the use of the	F 225	*The potential neglect of supervision after significant injury for R622 and R34, the bruising of unknown cause for R148, and allegation of abuse for R16 have been reported to the Administrator and/or state agency. *All allegations of potential neglect of supervision after significant injury, bruising of unknown cause, and potential abuse of vulnerable adults residing in the facility will be reported immediately to the Administrator and/or state agency and an investigation will be initiated. *All facility staff have been educated on the facility policy and procedure of immediate reporting of all potential neglect of supervision after significant injury, bruising of unknown cause, and potential abuse to the Administrator and/or state agency, per the Vulnerable Adult law. *Monitoring to ensure compliance will be conducted by the DON or designee through incident report review and the vulnerable adult reporting and tracking logs maintained by the facility on a monthly basis. *The facility QAPI committee will review the status of immediate reporting of allegations of abuse and/or injuries of unknown cause quarterly for further recommendations.	

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F 225	Continued From page 6	F 225		

antipsychotic medication Seroquel and the analgesic Tramadol used to treat moderate to moderately severe pain. The goal statement was for the resident to be "free from injury." Interventions included: maintaining a clutter free environment, keeping call light within reach, assisting resident with toileting and transfers, and assisting the resident with activities of daily living (ADLs) as needed or requested by the resident. Staff were directed to observe for changes in resident's gait, steadiness, self-mobility, judgment, coordination and strength. Safety devices included the use of a low bed and floor mat, and ensuring the resident wore proper footwear during transfers.

An incident report dated 3/1/15, revealed the resident had an unwitnessed fall and was found on the floor next to the bed with her head facing the window. The report indicated the resident had sustained a left elbow skin tear measuring 8 x 2 cm (centimeters) and that she had hit her head, but had no injury. The report indicated the resident was able to move all extremities and complained only of pain in her left elbow. Vital signs were taken and R622 was assisted off the floor by two staff. The care plan had subsequently been modified to include 15 minute safety checks. Nursing notes also dated 3/1/15, indicated R622 appeared confused and was having hip pain rated as the worst at 10 out of 10 possible. Subsequently X-rays to the hip, femur and knee area were ordered, and revealed the resident had sustained a superior and inferior pelvic fracture.

When interviewed on 3/13/15, at 8:30 a.m. the administrator and director of nursing (DON) verified they had not reported the fall with

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F 225	Continued From page 7	F 225		

significant injury, as they had viewed it as an accident.

R34's fracture after an unwitnessed fall at the facility was not reported to the SA for potential neglect of supervision.

R34 was observed on 3/5/14, at 1:30 p.m. while seated near the nursing station. Bruising was observed to both eyes and the nose, as well as her upper extremities, and the right arm was in a cast. The resident displayed agitation and behaviors making her unapproachable to interview.

R34's quarterly MDS dated 2/25/15, indicated the resident had a diagnosis of dementia, anxiety, depression, schizophrenia, psychosis, and abnormal coagulation (requiring blood thinning medication). The resident was cognitively intact, had behaviors directed towards others, and rejected cares. The resident required extensive assist of one person with transfers, locomotion on and off the unit and toileting, and did not use a walker or wheelchair.

Nursing notes dated 3/6/15, indicated R34 was heard screaming for help, and was found on the floor bleeding profusely. The resident stated she was trying to use the bathroom by herself without her walker and lost her balance and fell hard. The resident was on Coumadin 8 milligrams. The resident had broken dentures, bleeding upper lip, hematoma to nose area and bruises on both arms and knees. Range of motion was able to be performed on her left extremities. Her right arm was immobilized, ice was applied to right knee, and the physician was notified. The resident was sent to the hospital to evaluate and treat for

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F 225	Continued From page 8 possible right arm fracture. Physician notes dated 3/6/15, stated R34 had significant tenderness to right shoulder and arm, a distal radius, ulna, and nasal bone fractures, a 1.5 centimeter laceration under the chin, and multiple bruises to both upper extremities. R34's falls care plan dated 7/23/14, noted the resident was at high risk for falling due to psychotropic medication use, impaired safety judgment, and a history of falls. Staff were directed to maintain a clutter free environment, ensure call light was in reach and remind the resident to use it. An incident report was requested, but was not provided, therefore, it could not be determined whether the resident's environment was assessed to determine if all interventions were in place as written. When interviewed on 3/13/15, at 9:00 a.m. the administrator and DON verified R34 had sustained multiple injuries after a fall. The had not immediately reported the fall with serious injuries to the SA for potential neglect of supervision, as they had viewed it as an accident. The DON stated it was an isolated incident and the resident had not fallen prior to 3/6/15. R148's progress note date 1/22/15, indicated R148 fell apparently after falling asleep in her wheelchair. The fall was witnessed and the resident was described as sliding forward, landing on her knee and then sitting on the floor. The note indicated R148 did not hit her head and no injuries were noted at the time of the incident. An incident report dated 2/1/15, revealed a light greenish bruise was observed on the resident's	F 225		

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F 225	Continued From page 9	F 225		

right temple. The resident was unable to recall how the injury had occurred. The bruise measured 6.5 x 5 centimeters (cm) and was greenish in color with a 2 x 2 cm bump within the bruise. The report indicated the incident was not potentially reportable to the designated State agency (SA). The rationale was that the injury was related to a fall on 1/22/15, and the bruise was in the last stages of fading. However, the fall on 1/22/15, was witnessed and the resident "did not hit her head." Factors identified as relevant to the incident were, "Severe cognitive impairment and poor safety awareness; last fall 1/24/15 (details of this fall were not noted); has had multiple falls--bruising likely related to fall, bruise fading light greenish color." The injury was not immediately reported to the administrator or SA for potential neglect of supervision.

On 3/12/15, 8:09 a.m. RN-D stated that she knew nothing about the temple bruise until she received the incident report on 2/1/15. RN-D explained bruising of unknown origin would have been reported to the director of nursing (DON) and a decision would be made whether or not to report it. RN-D verified the incident had not been reported to the SA as it was believed to have occurred from a witnessed fall, as stated on the incident report. RN-D explained that incident reports were discussed at the interdisciplinary team (IDT) meetings each day, which were not unit specific, but where all residents in the building who experienced a fall were discussed.

NA-A, however, explained on 3/12/15 at 9:50 a.m. R148 "got the bruise [on her temple] from a fall during the night, not from slipping out of the wheelchair." NA-A worked the day shift and was unsure if an incident report had been filed. NA-A

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F 225	Continued From page 10	F 225		

could not recall the exact date, but added that he believed the fall had not been witnessed. RN-D then verified there were no other fall reports between 1/22/15 and 2/1/15, when the bruise was reported.

R148's MDS dated 2/12/15, revealed the resident had moderately impaired cognition, and required extensive assistance from staff to perform activitites of daily living.

A Weekly Body Audit form showed the resident's skin condition had only been assessed on two of the four weeks in 1/15. On 1/6/15 (week one) R148's skin was intact with no bruises noted, and on 1/20/15 (documented as week 2) again it was noted the resident had intact skin with no bruises noted. The form lacked documentation for the week prior to 2/1/15. On 3/11/15, 11:13 a.m. RN-D explained all bruises would have been assessed at 24-36 hours and documented on the initial incident form. The 24-36 hour follow-up assessment indicated no change to the resident's bruise.

R148 sustained a bruise to the chin that was not immediately reported to the administrator and SA.

On 3/11/15, at 10:41 a.m. a dime size faded bruise was observed on the left side of 148's chin. NA-A stated he noticed the bruise when he had returned to work after being off. He said R148 had stated it was from the nebulizer mask.

An incident report dated 2/23/15, indicated a bruise was noticed on R148's chin measuring 1.5 x 2 cm. The report indicated the incident was not potentially reportable to the SA. The rationale was that R148 had been combative with staff

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(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
F 225	Continued From page 11	F 225		

over the weekend according to staff interviews and previous incident reports.

On 3/11/15, at 11:13 a.m. RN-D explained that an incident report would have been completed and the bruise would have been re-assessed at 24-36 hours after the incident. She explained that R148 had been combative with cares and could have sustained the bruise at that time. RN-D said the resident had been combative during a nebulizer treatment and staff had attempted to hold the mask to R148's face.

The following day at 10:00 a.m. RN-D explained that R148 was often combative with cares and had been combative while getting a chest X-ray, which may have been a contributing factor. RN-D verified the cause of R148's bruise to the face was unknown.

R16's initial care conference was held on 2/24/15. During the conference, R16's family reported they had noticed bruises which looked like fingerprints on their mother's arms, and believed it was from staff holding her arms during transfers. Because of dementia, R16 was unable to provide any information regarding the cause of the bruises.

R16's admission MDS dated 2/21/15, revealed diagnoses including dementia, was rarely/never understood and had a short and long term memory problem. The MDS also indicated R16 required extensive assistance from two staff for activities of daily living (ADLs).

On 3/12/15, at 8:56 a.m. the administrator stated staff were trained to immediately notify their supervisor, DON or the administrator of any alleged abuse. The administrator defined

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 225	Continued From page 12 immediately "as soon as you are aware...It's in our policy not to exceed 24 hours." The administrator also stated after she and the DON discussed an incident and the DON and herself had discussed the incident and deemed the incident reportable, the DON would notify the supervisor to report the incident to the SA as soon as possible. The administrator also stated if there was a report of abuse and the resident was not cognitively intact, the facility would need to report to the SA right away and then start investigation. The administrator reiterated the DON and herself would decide together whether the incident was reportable or not, and when unsure would always report. The administrator said, "We report right away, we can't over report." On 3/12/15, at 1:28 p.m. the administrator stated that at the time R16's family notified facility staff of the bruising, they left with the resident for an appointment outside the facility. The administrator explained that she and the DON were waiting for R16 to return from her appointment. They had planned to make a comparison from the admission body audit and her current condition to determine whether the bruising was of unknown origin. The administrator further stated the facility wanted do "their due diligence first" and report the incident if needed. Additionally, the administrator also stated she and the DON knew the situation had the potential to be "reportable" to the SA, but wanted to "find out first if the bruise was of unknown origin." When R16 was not back in the facility the following day, a skin check was not possible, and it was decided they would report it to the SA. The facility's policy Vulnerable Adult Abuse Prohibition Plan dated 11/21/11, indicated "If	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 225	Continued From page 13 during the course of the investigation there is reasonable cause to suspect that mistreatment has occurred, the [SA would be notified]. A mandated reporter who has reason to believe that a VA (vulnerable adult) is being or has been maltreated, or who has knowledge that a VA has sustained a physical injury which is not reasonable explained will report...as soon as possible, but no more than 24 hours after discovery of the incident." The facility's 11/21/11, Vulnerable Adult Abuse Prohibition Plan defined neglect as "Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness, including but not limited to food, clothing, shelter, healthcare or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's (VA) physical or mental health or safety...." In addition, the policy indicated an injury of unknown origin was when "both of the following apply: 1) The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and 2) The injury is suspicious because the extent of the injury or location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		4/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 226	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to operationalize policies for abuse prohibition as required for 4 of 7 residents (R622, R34, R148, R16) reviewed for allegations of abuse and/or injuries of unknown origin. In addition, the facility's policy failed to direct staff to immediately report to the designated State agency (SA) any incidents or allegations of abuse. This had the potential to affect all residents residing in the facility. Findings include: The facility's policy Vulnerable Adult Abuse Prohibition Plan dated 11/21/11, indicated "If during the course of the investigation there is reasonable cause to suspect that mistreatment has occurred, the [SA would be notified]. A mandated reporter who has reason to believe that a VA (vulnerable adult) is being or has been maltreated, or who has knowledge that a VA has sustained a physical injury which is not reasonable explained will report...as soon as possible, but no more than 24 hours after discovery of the incident." In addition, the policy defined neglect as "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness, including but not limited to food, clothing, shelter, healthcare or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's (VA) physical or mental health or safety, considering the physical and mental capacity of dysfunction of the of the VA...." In addition, the policy indicated an injury of unknown origin is when both of the following apply: 1) The	F 226	*The facility vulnerable adult abuse prohibition policy and procedure has been revised to direct staff to immediately report to the designated state agency any incidents of allegations of abuse and/or injuries of unknown cause. *The facility vulnerable adult abuse prohibition policy and procedure will be operationalized for all allegations of abuse and/or injuries of unknown origin. *All facility staff have been educated on the revised facility vulnerable adult abuse prohibition policy and procedure of immediate reporting of all allegations of abuse and/or injuries of unknown cause. *Monitoring to ensure compliance will be conducted by the DON or designee through incident report review and the vulnerable adult reporting and tracking logs maintained by the facility on a monthly basis. *The facility QAPI committee will review the status of immediate reporting of allegations of abuse and/or injuries of unknown cause.	

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F 226	Continued From page 15	F 226		

source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and 2) The injury is suspicious because the extent of the injury or location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time.

R622 sustained a fracture after an unwitnessed fall at the facility that was not immediately reported to the SA for potential neglect of supervision.

R622's history and physical dated 2/26/17, noted the resident fell at home and sustained a lumbar compression fracture. After hospitalization from 2/17/15 to 2/27/15, the resident was admitted to the nursing home with acute delirium (a quick, severe, and short lived mental disorder), lumbar vertebral fracture, ataxia (abnormal gait), with a history of falls noted.

R622's 2/27/15, Safety Risk Assessment noted the resident did not display behavioral problems, but had a history of falls and a floor mat would be used. An initial care plan also dated 2/27/15, noted a potential/actual alteration in safety, falls related to weakness, balance impairment, cognitive impairment, poor judgment, impulsiveness, agitation, as well as the use of the antipsychotic medication Seroquel and the analgesic Tramadol used to treat moderate to moderately severe pain. The goal statement was for the resident to be "free from injury." Interventions included: maintaining a clutter free environment, keeping call light within reach, assisting resident with toileting and transfers, and assisting the resident with activities of daily living (ADLs) as needed or requested by the resident.

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 226	Continued From page 16	F 226		

Staff were directed to observe for changes in resident's gait, steadiness, self-mobility, judgment, coordination and strength. Safety devices included the use of a low bed and floor mat, and ensuring the resident wore proper footwear during transfers.

The incident report dated 3/1/15, revealed the resident had an unwitnessed fall and was found on the floor next to the bed with her head facing window. The resident sustained a left elbow skin tear measuring 8 x 2 cm and hit her head with no injury. The resident was able to move all extremities and complained of pain on her left elbow. Vital signs were taken and R622 was assisted off the floor by two staff. The care plan was then updated to include 15 minute safety checks. Nursing notes also dated 3/1/15, then showed R622 appeared confused and was having hip pain rated as the worst at 10 out of 10 possible. X-rays to the hip, femur and knee area were ordered, and revealed the resident had sustained a superior and inferior pelvic fracture.

When interviewed on 3/13/15, at 8:30 a.m. the administrator and director of nursing (DON) verified they had not reported the fall with significant injury, as they had viewed it as an accident.

R34's fracture after an unwitnessed fall at the facility was not reported to the SA for potential neglect of supervision.

R34 was observed on 3/5/14, at 1:30 p.m. while seated near the nursing station. Bruising was observed to both eyes and the nose, as well as her upper extremities, and the right arm was in a cast.

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 226	Continued From page 17 Nursing notes dated 3/6/15, indicated R34 was heard screaming for help, and was found on the floor bleeding profusely. The resident stated she was trying to use the bathroom by herself without her walker and lost her balance and fell hard. The resident was on Coumadin 8 milligrams. The resident had broken dentures, bleeding upper lip, hematoma to nose area and bruises on both arms and knees. Range of motion was able to be performed on her left extremities. Her right arm was immobilized, ice was applied to right knee, and the physician was notified. The resident was sent to the hospital to evaluate and treat for possible right arm fracture. Physician notes dated 3/6/15, stated R34 had significant tenderness to right shoulder and arm, a distal radius, ulna, and nasal bone fractures, a 1.5 centimeter laceration under the chin, and multiple bruises to both upper extremities. R34's falls care plan dated 7/23/14, noted the resident was at high risk for falling due to psychotropic medication use, impaired safety judgment, and a history of falls. Staff were directed to maintain a clutter free environment, ensure call light was in reach and remind the resident to use it. An incident report was requested, but was not provided, therefore, it could not be determined whether the resident's environment was assessed to determine if all interventions were in place as written. When interviewed on 3/13/15, at 9:00 a.m. the administrator and DON verified R34 had sustained multiple injuries after a fall. The had not immediately reported the fall with serious injuries to the SA for potential neglect of supervision, as	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 18	F 226		

they had viewed it as an accident. The DON stated it was an isolated incident and the resident had not fallen prior to 3/6/15.

R148's progress note date 1/22/15, indicated R148 fell apparently after falling asleep in her wheelchair. The fall was witnessed and the resident was described as sliding forward, landing on her knee and then sitting on the floor. The note indicated R148 did not hit her head and no injuries were noted at the time of the incident.

An incident report dated 2/1/15, revealed a light greenish bruise was observed on the resident's right temple. The resident was unable to recall how the injury had occurred. The bruise measured 6.5 x 5 centimeters (cm) and was greenish in color with a 2 x 2 cm bump within the bruise. The report indicated the incident was not potentially reportable to the designated State agency (SA). The rationale was that the injury was related to a fall on 1/22/15, and the bruise was in the last stages of fading. However, the fall on 1/22/15, was witnessed and the resident "did not hit her head." Factors identified as relevant to the incident were, "Severe cognitive impairment and poor safety awareness; last fall 1/24/15 (details of this fall were not noted); has had multiple falls--bruising likely related to fall, bruise fading light greenish color." The injury was not immediately reported to the administrator or SA for potential neglect of supervision.

On 3/12/15, 8:09 a.m. RN-D stated that she knew nothing about the temple bruise until she received the incident report on 2/1/15. RN-D explained bruising of unknown origin would have been reported to the director of nursing (DON) and a decision would be made whether or not to report

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 226	Continued From page 19	F 226		

it. RN-D verified the incident had not been reported to the SA as it was believed to have occurred from a witnessed fall, as stated on the incident report. RN-D explained that incident reports were discussed at the interdisciplinary team (IDT) meetings each day, which were not unit specific, but where all residents in the building who experienced a fall were discussed.

NA-A, however, explained on 3/12/15 at 9:50 a.m. R148 "got the bruise [on her temple] from a fall during the night, not from slipping out of the wheelchair." NA-A worked the day shift and was unsure if an incident report had been filed. NA-A could not recall the exact date, but added that he believed the fall had not been witnessed. RN-D then verified there were no other fall reports between 1/22/15 and 2/1/15, when the bruise was reported.

R148's MDS dated 2/12/15, revealed the resident had moderately impaired cognition, and required extensive assistance from staff to perform activities of daily living.

R148 sustained a bruise to the chin that was not immediately reported to the administrator and SA.

On 3/11/15, at 10:41 a.m. a dime size faded bruise was observed on the left side of 148's chin. NA-A stated he noticed the bruise when he had returned to work after being off. He said R148 had stated it was from the nebulizer mask.

An incident report dated 2/23/15, indicated a bruise was noticed on R148's chin measuring 1.5 x 2 cm. The report indicated the incident was not potentially reportable to the SA. The rationale was that R148 had been combative with staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	03/13/2015

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WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 226	Continued From page 20	F 226		

over the weekend according to staff interviews and previous incident reports.

On 3/11/15, at 11:13 a.m. RN-D explained that an incident report would have been completed and the bruise would have been re-assessed at 24-36 hours after the incident. She explained that R148 had been combative with cares and could have sustained the bruise at that time. RN-D said the resident had been combative during a nebulizer treatment and staff had attempted to hold the mask to R148's face.

The following day at 10:00 a.m. RN-D explained that R148 was often combative with cares and had been combative while getting a chest X-ray, which may have been a contributing factor. RN-D verified the cause of R148's bruise to the face was unknown.

R16's initial care conference was held on 2/24/15. During the conference, R16's family reported they had noticed bruises which looked like fingerprints on their mother's arms, and believed it was from staff holding her arms during transfers. Because of dementia, R16 was unable to provide any information regarding the cause of the bruises.

On 3/12/15, at 8:56 a.m. administrator stated staff were trained to immediately notify their supervisor, director of nursing (DON) or the administrator of any alleged abuse. The administrator defined immediately as "soon as you are aware...It's in our policy not to exceed 24 hours." The administrator also stated after the DON and herself had discussed the incident and deemed the incident reportable, the DON would notify the supervisor to report the incident to the

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 226	Continued From page 21 SA as soon as possible. The administrator also stated if there was a report of abuse and the resident was not cognitively intact, the facility would need to report to the SA right away and then start investigation. The administrator reiterated the DON and herself would decide together whether the incident was reportable or not, and when unsure would always report. The administrator said, "We report right away, we can't over report." On 3/12/15, at 1:28 p.m. the administrator stated that at the time R16's family notified facility staff of the bruising, she (R16) then left for an appointment outside the facility. The administrator also stated she and the DON were waiting for R16 to return from her appointment so a comparison could be made between her admission body audit and the current condition of the resident's skin to determine whether the bruising was of unknown origin. The administrator further stated the facility wanted do "their due diligence first" and report the incident if needed. Additionally, the administrator also stated she and the DON knew the situation had the potential to be "reportable" to the SA, but wanted to "find out first if the bruise was of unknown origin." When R16 was not back in the facility the following day, a skin check was not possible, and at that time it was decided it would be reported to the SA.	F 226		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252		4/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 252	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure comfortable water temperatures in resident rooms for 2 of 40 sampled residents (R466, R269) whose rooms were observed. Findings include: R466 reported on 3/9/15, at 3:40 p.m. that the temperature of the water from the sink faucet in his bathroom was too cold. The water temperature was then checked and after running the hot water for approximately three minutes, the temperature remained cool to the touch. R269 also reported on 3/10/15, at 2:09 p.m. that the hot water from the sink faucet in her bathroom was too cold. After running the faucet for a couple of minutes, the water remained cool to the touch. At 2:24 p.m. at the time the resident was interviewed, the water in the bathroom felt cool and the resident stated, "The water in the bathroom is too cold." A tour of the facility environment was conducted on 3/11/15, with the administrator, the corporate environmental services director (ESD), and the housekeeping/laundry supervisor. ESD, during the 3/11/15, tour at 3:22 p.m. indicated he had not been informed of the cool water temperatures. He tested the tap water in room 549 at 3:15 p.m. with an infrared thermometer and stated, "It's not in range right now, which is interesting. Unfortunately, you're	F 252	*Water temperatures in the rooms of R466 and R269 have been adjusted to reach comfortable water temperatures. *Water temperatures in all resident rooms have been adjusted to reach comfortable water temperatures. *All facility staff have been educated on the use of the Work Request email, front desk logs, or unit work request binders to communicate resident concerns regarding water temperatures to maintenance. Maintenance staff have been educated on proper water temperature ranges and implementation of the weekly preventative maintenance log for water temperatures. *Monitoring to ensure compliance will be conducted by the Maintenance Supervisor or designee through random daily audits of the water temperature in resident rooms. *The facility QAPI committee will review the results of the water temperature audits quarterly for further recommendations.	

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 252	Continued From page 23 correct. It's still temping [registering] at 80 degrees...It definitely shouldn't be taking this long." He explained that the reason was likely due to the need to adjust a valve in the ceiling and the feed to the room. He added that they wanted the minimum temperature to fall "between 110-112 degrees" with the minimum temperature registering 106 degrees. On 3/12/15, at 4:12 p.m. the ESD indicated environmental services staff received concerns from any staff, resident or visitor to the facility. He added, "We get our information from the computer [email], from the front desk calls log [staff or residents calling the front desk, where a paper log was checked periodically by environmental services staff], and from paper requests in boxes on the units--and we act as soon as possible." Additionally he indicated the facility did not utilize a preventive maintenance plan to identify issues. The facility's undated policy, Domestic Hot Water Monitoring Procedure indicated, "Potable domestic hot water is monitored constantly through our building automation system. The systems parameters are set at 105 degrees (low temp) and 115 degrees (high temp). If the building supply hot water falls below or raises above these predetermined temperatures the computer located in the maintenance office will indicate and alarm notifying staff of the situation."	F 252		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a	F 257		4/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 257	Continued From page 24 temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain comfortable room temperatures for 4 of 40 sampled residents (R466, R269, R296, R205) whose rooms were observed. Findings include: R466 replied "Yes" on 3/10/15, at 1:24 p.m. when asked if he had any problems with the temperature in the building that may have affected his comfort. He explained the staff entered his room without asking and opened the window. When the resident returned to his room "It is really cold." R205 stated on 3/10/15, at 2:02 p.m. she had experienced problems with excessive heat in her room, describing it as "stifling in here within the last month, but now we can have the windows open and the fresh air helps. Maintenance...messed with the thermostat, but the register still puts out too much heat." R269 reported on 3/10/15, at 2:09 p.m. she had concerns about the building temperatures that affected her comfort, "Yes--it's either too hot or too cold in my room." R296 stated on 3/10/15, at 3:02 p.m. "The heating doesn't work too well--too cold in winter. I told them and nothing happened." He added the problem was on one side of the room and said, "The temp drops to 68 degrees. I'd rather have it	F 257	*Room temperatures for R466, R269, R 296 and R205 have been adjusted to ensure appropriate comfort levels. *Room temperatures in all resident rooms have been checked and adjusted to ensure appropriate comfort levels. *All facility staff have been educated on the use of the Work Request email, front desk logs, or unit work request binders to communicate resident concerns regarding room temperatures to maintenance. Maintenance staff have been educated on proper room temperature ranges and implementation of the weekly preventative maintenance log for room temperatures. *Monitoring to ensure compliance will be conducted by the Maintenance Supervisor or designee through random daily audits of the room temperature in resident rooms. *The facility QAPI committee will review the results of the room temperature audits quarterly for further recommendations.	

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 257	Continued From page 25 at 72 degrees. It's not a window draft." A tour of the facility environment was conducted on 3/11/15, at approximately 3:00 p.m. with the administrator, corporate environmental services director (ESD), and the housekeeping/laundry supervisor (HLS). The ESD explained during a tour of 5 Raines that he was unaware of R466's problem with staff opening the resident's window. A temperature reading registered 80 degrees Fahrenheit (F), which was consistent with the thermostat reading. The window was shut at the time of the tour. The administrator explained that staff could open a window, but that it should have been at the request of a resident, and there was "no reason for staff to do it on their own." R269 was present when the environmental tour continued on the 5 Raines unit. At the time of the tour R269 added, "There is no relation to the time of day. I let them know. They came to fix it. It helped for a short time." The ESD stated he had no knowledge of the problem and added, "I will check the log. The baseboard heater is controlled by the wall thermostat. I get 76 degrees by the temp gun and the wall thermostat is at 75 degrees." The ESD said the problem may have been related to thermostat adjustment ("moved by the resident or family"). R296 resided on 1 Raines and when her room was checked on the tour the ESD looked at the left interior wall and stated, "Something was done with this room years ago and this part of the room has no thermostat. I will look into that." As the tour continued on 1 Raines the ESD	F 257		

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 257	Continued From page 26 stated, "We just turned on the air conditioning." Although he said the heater was not running at the time, he measured the temperature at the baseboard which read 76 degrees. R205 then added, "They were in already today changing the thermostat." On 3/12/15, at 4:12 p.m. the ESD indicated the environmental services staff received environmental concerns from any staff, resident or visitor to the facility. He added, "We get our information from the computer [email], from the front desk calls log [staff or residents calling the front desk, where a paper log was checked periodically by environmental services staff], and from paper requests in boxes on the units, and we act as soon as possible." Additionally he indicated the facility did not use a preventive maintenance plan to identify issues. On 3/13/15, a policy for maintaining comfortable temperatures in the building was requested, but was not provided.	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		4/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 27 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop the care plan with individualized interventions to protect 1 of 3 residents (R148) from falls, as well as for monitoring and minimizing the risk for further bruising for 1 of 4 (R524) residents reviewed for non-pressure related skin issues. Findings include: R148 experienced 12 reported falls from 10/14 through 2/15. R148 also sustained a bruise to the temple from an unknown and unreported incident. The facility failed to develop and implement interventions in a timely manner to minimize the risk for further falls. On 3/12/15, at 7:44 a.m. a registered nurse (RN)-D explained when a fall happens an assessment of possible causes would be done, such as, time of day, if the resident was trying to get to the, bathroom, signs of illness and so on. RN-D explained that incident reports were also discussed at the interdisciplinary team (IDT) meetings each day, but the meetings were for the entire facility, not by nursing unit. Therefore, the team members at the meetings had limited	F 279	*The care plan for R148 has been developed with individualized interventions to protect R148 from falls. The care plan for R524 has been developed with individualized interventions for monitoring and minimizing the risk for further bruising. *The care plans for all residents assessed to be at increased risk for falls have been developed with individualized interventions to protect from falls. The care plans for all residents assessed to be at increased risk for non-pressure related skin issues have been developed with individualized interventions to monitor and minimize the risk for bruising. *All complex supervisors and nurse managers have been educated on the requirement to develop a care plan with individualized interventions to protect residents from falls and to develop a care plan with individualized interventions to monitor and minimize the risk for non-pressure related skin issues. *Monitoring to ensure compliance will be conducted by the DON or designee through audits of the resident care plan	

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F 279	Continued From page 28 working knowledge of the individual cases discussed. Also, RN-D explained that the assistant director of nursing (ADON) was responsible for reviewing and investigating all falls for trends or patterns in order to develop appropriate interventions. R148 resided on a locked memory care unit due to cognitive deficits. The last full comprehensive assessment was completed on 11/13/14, due to a significant change in status. At the time of the comprehensive assessment, R148 was not steady, only able to stabilize with human assistance and required assist of one with balance during transfers and walking. R148 used a wheelchair for mobility. R148's mood had changed and was displaying more episodes of being short tempered, resisting cares and wandering. Also, R148 was assessed as having psychosis, which was a change since the prior quarterly assessment on 10/14/14. A Safety Risk Assessment (SRA) was completed on 11/13/14. The assessment indicated fall risk factors of balance problems, incontinence, and a medication to control blood pressure. Interventions to prevent falls included a sensor alarm, secured unit, and re-direction. The outcome section indicated "unsuccessful, resident continues to wander." The assessment indicated R148 yelled at staff, called names, made racial slurs, and refused cares. An SRA completed on 2/12/15, indicated multiple falls possibly related to urinary tract infection, working with occupational therapy for wheelchair positioning. Physical therapy also initiated, has bed/chair alarm due to multiple falls.	F 279	for individualized interventions after an occurrence of a fall or incident of non-pressure related skin issues. *The facility QAPI committee will review the results of the care plan audits quarterly for further recommendations.	

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F 279	Continued From page 29	F 279		

The care plan for R148 dated 1/17/14, indicated an alteration in safety for falls related to behavior of wandering, balance impairment, coronary artery disease, incontinence, and impaired safety judgement secondary to dementia. Also written in (no date) was history of falling asleep in wheelchair and refusing to lay down between meals. The goal was for R148 to be free from falls and injury daily.

Interventions listed were: Determine interventions based on SRA and observations; Maintain a clutter free environment; Keep personal items and call light within reach; Remind and encourage to use call light; ensure properly fitting shoes with non skid soles for transfers; Assist resident with activities of daily living per resident need and request; Occasionally ambulatory with walker and assist of one; Use wheelchair on and off unit; Follow facility fall protocol; Alarm on at all times; Hip protectors on at all times as resident will allow, refuses a lot, non compliant. Also included on the care plan as updates were: Offer to lie down between meals-refuses (no date); Occupational therapy for wheelchair positioning 2/10/15, and tilt in space wheelchair, 2/2015.

The fall care plan lacked specific and individualized interventions related to identified fall risks of wandering, balance impairment, attempts to self transfer, and incontinence. Also identified on the care plan was that R148 refused to lie down between meals, but no replacement intervention was identified. The incident report on 2/4/15 indicated frequent checks and offer to be in the common area as interventions, but those interventions were lacking from the care plan. R148 sustained 7 unwitnessed falls in her room before an intervention of frequent checks or

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F 279	Continued From page 30	F 279		

attempting to keep the resident under observation was suggested.

The policy titled Falls Assessment, Management and Prevention revised on 3/12/14, indicated the Safety Risk Assessment (SRA) would be based on the nursing assessment and resident's history. The care plan was to be initiated based on the results of the SRA. The care plan would be individualized to reflect the specific needs and risk factors of the resident.
R524 was observed while sitting in her room on 3/10/15 at 5:32 p.m. The resident had large purplish (but not new in appearance) bruises on the back of each hand.

During an interview on 3/12/15, at 10:30 a.m. R524 said she did not know how she had sustained the bruises. When asked if she had been gripped too hard by someone she replied emphatically, "No, no, no!"

R524 was admitted on 2/19/15, and medical diagnoses included atrial flutter (a heart problem), acute kidney failure, end stage kidney failure, and anemia (low hemoglobin).

The most recent International Normalized Ratio (INR - to assess blood coagulation) value was high on 3/11/15 at 1.72 (indicting increased risk of bleeding, and therefore bruising).

During an interview on 3/13/15, at 1:53 p.m., a licensed practical nurse (LPN)-G stated R524, "...has a skin tear on the right wrist and left upper arm, and a bruise on the back of the hands."

A registered nurse (RN)-E also said in an interview on 3/13/15, at 10:57 a.m. R524 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 31	F 279		

fading large bruises on the backs of both hands. He explained the resident had been living alone at home, and was admitted to the hospital with "bruises all over" after being found on the floor. The resident had a history of falls and had been resistive to accepting care in her home. She also had a skin tear on admission. RN-E stated, "We do a weekly body audit with showers to monitor the bruising. We would do an incident report if we noted any new bruising (a form yellow in color was used for an incident like a new bruise or skin tear)." However, on 3/13/15, at 12:15 p.m. the nurse verified he could not locate any body audits in R524's medical record. When checking for information related to the bruising, he could not find it had been monitored on the resident's treatment record. RN-E reported, "The last actual weekly shower day body audit I have is dated 2/22/15. I would have expected to see 3/1 and 3/8 would have been done - we are supposed to do them every Sunday."

A review of the medication administration record (MAR) for 2/15 and 3/15, revealed direction for "Nurse to complete weekly body audit and weekly weight on shower day." A handwritten addition read: "Sun AM," with those days boxed out where staff was to have initialed the audit had been completed. The MAR had no staff initials on 2/22/15, 3/1/15, or 3/8/15.

R524's admission body audit revealed multiple bruises on most body surfaces, including the backs of both hands, but the audit did not include any actual measurements or descriptions of the injuries. No other body audits could be located in the medical record.

R524's progress notes from admission to 3/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 32 revealed references to a skin tear on 2/21/15, but made no references to monitoring of bruising. The Minimum Data Set dated 3/6/15, indicated R524 had not experienced falls since her admission, and had been receiving anticoagulant medication. The care plan dated 3/10/15 noted the resident had "impaired skin integrity due to skin tear on arm wound," Staff were directed to complete dressing changes and monitoring to a left bicep wound. No reference was made to the resident's multiple bruises nor were goals and interventions developed.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin injections were properly prepared prior to administration in accordance with manufacturer's instructions and standards of practice for 1 of 1 resident (R308) whose insulin administration was observed. Findings include: R308's insulin administration was observed on 3/11/15 at 12:07 p.m. by a licensed practical nurse (LPN)-D. The medication was Humalog insulin administered via a Humalog KwikPen,(disposable dial-a-dose insulin pen).	F 281	*Insulin injections are properly prepared prior to administration in accordance with manufacturer's instruction and standards of practice for R308. *All insulin injections via insulin pen are properly prepared prior to administration in accordance with manufacturer's instruction and standards of practice for all residents receiving insulin injections. *All licensed nurses have been educated on the requirement to properly prepare insulin pens in accordance with manufacturer's instruction and standards of practice prior to administering insulin injections for all residents.	4/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 281	Continued From page 33 LPN-D attached the needle to the KwikPen, dialed to 12 units, wiped the resident's skin with an alcohol wipe and then administered the insulin to R308 upper right quadrant. Immediately after leaving R308's room, LPN-D was interviewed regarding the lack of priming or removing air from the cartridge in the KwikPen after the needle was attached. LPN-D verified she had not primed the KwikPen prior to administering R308's insulin. During an interview on 3/11/15, at 12:34 p.m. LPN-E explained that the expectation was that all residents who received insulin via a KwikPen should have had the pen primed before insulin was administered. R308's physician orders dated 2/18/15, directed staff to administer Humalog (medication used to manage diabetes) injections subcutaneous of 16 units every morning, 8 units daily at lunch time, and 6 units every evening and per sliding scale (based on blood sugar readings) three times a day before meals. The Humalog KwikPen manufacturer's instruction (revised 1/30/13) directed priming prior to administration of each injection. "Priming ensures the Pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin." The manufacturer's instruction insert went on to include step-by-step instructions on how to complete the task. According to those instructions, the standard of practice for priming the pump for insulin administration would have included holding the pen with the needle pointing up, tapping the cartridge holder gently to collect the air bubbles at the top, and visualizing a	F 281	*Monitoring to ensure compliance will be conducted by the DON or designee through random medication administration audits specific to insulin injections. *The facility QAPI committee will review the results of the medication administration audits quarterly for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 281	Continued From page 34 stream of insulin from the needle.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to monitor bruising for 1 of 3 residents (R524) and failed to determine the cause of a significant bruise for 1 of 3 residents (R148) reviewed for non-pressure related skin issues. Findings include: R524 was observed in her room on 3/10/15 at 5:32 p.m. The resident had large purplish bruises on the back of each hand (not new in appearance). During an interview on 3/12/15, at 10:30 a.m. R524 said she did not know how she had sustained the bruises. When asked if she had been gripped too hard by someone she replied emphatically, "No, no, no!" R524 was admitted on 2/19/15, and an admission body audit revealed multiple bruises on most body surfaces, including the backs of both hands, but the audit did not include any actual measurements or descriptions of the injuries. No	F 309	*R524 has been discharged from the facility. The significant bruise sustained by R148 has since resolved and R148 remains at baseline. *All new, non-pressure related skin issues will be documented on an incident report containing information to determine the cause. All non-pressure related skin issues will be monitored weekly via the weekly body audits tool until the issue is resolved. *All licensed nurses have been educated on the requirement to complete an incident report on all new, non-pressure related skin issues to determine the cause. All licensed nurses have been educated on timely completion and documentation of the weekly body audit tool until issue is resolved. Education included signing off completion in the treatment record. *Monitor to ensure compliance will be completed by the DON or designee	4/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 309	Continued From page 35 other body audits could be located in the medical record. The care plan dated 3/10/15 noted the resident had "impaired skin integrity due to skin tear on arm wound." Staff were directed to complete dressing changes and monitoring to a left bicep wound. No reference was made to the resident's multiple bruises were referenced nor goals and interventions developed. The medication administration record (MAR) for R524 for 2/15 and 3/15, revealed direction for "Nurse to complete weekly body audit and weekly weight on shower day." A handwritten addition read "Sun AM," with those days boxed out where staff was to have initialed the audit had been completed. The MAR had no staff initials on 2/22/15, 3/1/15 or 3/8/15. R524's progress notes from admission to 3/13/15 revealed references to a skin tear on 2/21/15, but made no references to monitoring of bruising. The Minimum Data Set dated 3/6/15, indicated R524 had not experienced falls since her admission, and had been receiving anticoagulant medication. The most recent International Normalized Ratio (INR--to assess blood coagulation) value was high on 3/11/15 at 1.72 (indicating increased risk of bleeding, and therefore bruising). A registered nurse (RN)-E said in an interview on 3/13/15, at 10:57 a.m. R524 had fading large bruises on the backs of both hands. He explained the resident had been living alone at home, and was admitted to the hospital with "bruises all over" after being found on the floor. The resident had a history of falling had been resistive to	F 309	through incident report review on all new, non-pressure related skin issues for completion and determination of cause. Random audits will be completed to ensure timely completion and documentation of the weekly body audit tool until issue is resolved, including signing off on the treatment record. *The facility QAPI committee will review the results of the incident report, body audits, and TAR documentation audits quarterly for further recommendations.	

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 309	Continued From page 36	F 309		

accepting care in her home. She also had a skin tear upon admission. RN-E stated, "We do a weekly body audit with showers to monitor the bruising. We would do an incident report if we noted any new bruising." However, on 3/13/15, at 12:15 p.m. the nurse verified he could not locate any body audits in R524's medical record. When checking for information related to the bruising, he could not determine whether the injuries had been monitored on the resident's treatment record. RN-E reported, "The last actual weekly shower day body audit I have is dated 2/22/15. I would have expected to see 3/1 and 3/8 would have been done. We are supposed to do them every Sunday."

During an interview on 3/13/15, at 1:53 p.m. a licensed practical nurse (LPN)-G then stated R524 had a "skin tear on the right wrist and left upper arm, and a bruise on the back of the hands."

R148's incident report was filed on 2/1/15, indicated a noted light greenish bruise on the right temple, and the resident could not recall how the bruise happened. The bruise measured 6.5 x 5 centimeters (cm) and was greenish in color with a 2 x 2 cm bump within the bruise. Interventions were to continue to monitor. Factors identified as relevant to the incident were, "Severe cognitive impairment and poor safety awareness; last fall 1/24/15; has had multiple falls--bruising likely related to fall, bruise fading light greenish color."

A progress note date 1/22/15 indicated R148 fell from her wheelchair apparently after falling asleep. It was witnessed and the resident was described as sliding forward and landing on her

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F 309	Continued From page 37 knee and then sat on the floor. The note indicated R148 did not hit her head and no injuries were noted at the time of the incident. On 3/12/15, 8:09 a.m. RN-D stated that she knew nothing about the temple bruise until she received the incident report on 2/1/15. RN-D explained that incident reports were discussed at the interdisciplinary team (IDT) meetings each day, in which all residents who had falls in the building were discussed. NA-A, however, explained on 3/12/15 at 9:50 a.m. R148 "got the bruise [on her temple] from a fall during the night, not from slipping out of the wheelchair." NA-A worked the day shift and was unsure if an incident report had been filed. NA-A could not recall the exact date, but added that he believed the fall had not been witnessed. RN-D then verified there were no other fall reports between 1/22/15 and 2/1/15, when the bruise was reported. Only two of the four weeks had been completed according to the Weekly Body Audit form for 1/15. On 1/6/15 (week one) R148's skin was intact with no bruises noted, and on 1/20/15 (documented as week 2) again it was noted the resident had intact skin with no bruises noted. The form lacked documentation for the week prior to 2/1/15. On 3/11/15 11:13 a.m. RN-D explained all bruises would have been assessed at 24-36 hours and documented on the initial incident form. The 24-36 hour follow-up assessment indicated no change to the resident's bruise.	F 309		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		4/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356 SS=C	Continued From page 38 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure daily nursing staffing hours reports were posted in a legible and accurate manner. This had the potential to	F 356	*The daily nursing staffing hours have been posted in a legible and accurate manner. *The daily nursing staffing hours will be	

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F 356	Continued From page 39 affect the 319 residents residing in the facility and visitors. Findings include: During initial tour on 3/9/15, at 8:36 a.m. the facility's Nurse Staffing Hours report dated 3/9/15, was observed in a clear plastic sleeve on the wall near the front reception desk. The nursing shift actual hours worked had been blackened out, making the document illegible. The report dated 3/9/15, was missing the evening's nursing hours. Behind the 3/9/15, report were additional reports from previous days from 3/6 to 3/8/15. Those reports also lacked nursing hours for the evening shift and the actual hours listed were illegible. At the time of the observation, the administrative assistant verified the postings were incomplete and illegible. On 3/11/15, at 10:41 a.m. the receptionist verified the Nursing Staffing Report dated 3/11/15, was missing the evening staffing information and the postings were illegible. On 3/11/15, at 1:27 p.m. the administrator stated the overnight complex supervisor posted the Nursing Staffing Report "sometime on the night shift." The administrator also stated the overnight supervisor was the only staff who filled out and completed the reports. On 3/11/15, at 1:59 p.m. the director of nursing (DON) stated the night supervisor posted the daily Nursing Staffing Reports. DON also stated she just checked the reports daily to ensure they were posted. A policy related to posting of nursing hours was	F 356	posted in a legible and accurate manner on a daily basis. *All complex supervisors have been educated on the requirement to post the daily nursing staffing hours in a legible and accurate manner on a daily basis. *Monitoring to ensure compliance will be completed by the DON or designee through daily audits of the staffing hours to ensure posting is legible and accurate. *The facility QAPI committee will review the results of the daily staffing hours audits quarterly for further recommendation.	

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F 356	Continued From page 40 requested of the facility staff on 3/13/15, but was not provided.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure kitchenette freezers were maintained in sanitary condition in a sampling of 2 of 5 kitchenettes. This had the potential to affect 58 residents residing on those units. Findings include: During an initial tour on 3/9/15, at 8:47 a.m. two ice packs were stored with residents' ice cream in the freezer in the kitchenette on the fourth floor long term care unit. At 12:04 p.m. a registered nurse (RN)-G stated the ice packs came from the pharmacy and were not supposed to be stored in the freezer with food. During an interview on 3/12/15, at 8:30 a.m. the assistant dietary manager (ADM) explained the nurses put ice packs in freezers for easy access.	F 371	*All ice packs have been removed from the kitchenette freezers on the first and fourth floor to maintain sanitary conditions. *All freezers in the kitchenettes are free from ice packs to maintain sanitary conditions. *All staff have been educated on proper storage, preparation and distribution of food under sanitary conditions, including the proper storage of food and non-food items in the freezer. *Monitoring to ensure compliance will be conducted by the DON or designee through random audits of kitchenette freezers for non-food item storage. *The facility QAPI committee will review the results of the non-food storage audits quarterly for further recommendations.	4/22/15

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F 371	Continued From page 41 She stated, "Food products are enclosed in boxes or in trays, and are not in contact with the packs." The following day at 9:16 a.m. the ADM added, the facility had no specific policy related to the storage of ice packs in the kitchenettes. On 3/13/15, at 8:04 a.m. a Flexitone hot or cold pack was stored along side residents' food, including waffles, meat labeled "turkey breast" and ice cream in the kitchenette freezer on Walker Court. At the time of the observation a nursing assistant (NA)-B verified the ice pack was stored with food and stated, "That is not supposed to be in there." NA-B explained the ice packs were utilized on residents' bodies, and therefore should have instead been stored in the medication freezer. A licensed practical nurse (LPN)-F then said she did not know why the ice pack was stored in the kitchenette freezer. On 3/13/15, at 11:21 a.m. the director of nursing (DON) stated the ice packs possibly came from the pharmacy. The DON did not comment as to where the ice packs should have or should not have been stored. The facility's 7/11/12, Infection Control Culinary Services policy indicated, "All food is to be stored, prepared, distributed and served under sanitary conditions."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		4/22/15

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F 431	Continued From page 42 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure expired insulin medications for (R96, R31, R496) were removed from 2 of 2 medication carts on 7 Gamble odd side and for 1 of 2 medication carts on 5 Raines even side, identified during medication storage review.	F 431	*The expired insulin pens have been removed from the Gamble 7 odd side medication cart and the Raines 5 even side medication cart. *All expired insulin pens have been removed from all facility medication carts. All medication carts are free from expired insulin.	

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F 431	Continued From page 43 Findings include: The facility's medication storage system was observed on the Gamble 7 unit (odd side cart) and Raines 5 unit (even side cart) on 3/9/15, at 8:41 a.m. Expired insulin labeled for R31, R96 and R496 was stored at room temperature in the cart. R31's Novolog had an opened date of 1/30/15. R496's Lantus had an opened date of 1/19/15. R96's Lantus had no opened date and 150 units or 1.5 ml was left in the Lantus pen; the last refill date was 1/17/15. Manufacturers' instructions revealed both Lantus and Novolog insulin expired in 28 days once opened. R96's care plan dated 1/21/15, identified the potential for an alteration in the resident's endocrine system related to the diagnosis of diabetes. Interventions included administering diabetic medications and/or insulin according to the physician orders. R96's March 2015 Medication administration Record (MAR) indicated the resident was to receive 14 units of Lantus insulin by subcutaneous injection daily at hours of sleep. R31's care plan dated 10/10/14, identified the potential for an alteration in the resident's endocrine system related to the diagnosis of diabetes. Interventions included administering diabetic medications and/or insulin according to the physician orders. R31's March 2015 MAR indicated the resident was to receive 10 units of Novolog insulin 100 /milliliter (ml) by subcutaneous injection three times daily. R496's care plan dated 4/30/15, identified the	F 431	*All licensed nursing staff have been educated on the removal of expired insulin from the medication carts per pharmacy policy and procedure. *Monitoring to ensure compliance will be conducted by the DON or designee through random audits of medication carts for expired insulin. *The facility QAPI committee will review the results of the medication cart audits quarterly for further recommendations.	

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F 431	Continued From page 44 potential for an alteration in the resident's endocrine system related to the diagnosis of diabetes. Interventions included administering diabetic medications and/or insulin according to the physician orders. R496's March 2015 MAR indicated the resident was to receive 8 units of Lantus insulin by subcutaneous injection every evening. During an interview on 3/9/15, at 10:09 a.m. two licensed practical nurses (LPN)-B and (LPN)-C confirmed the insulin had expired for R31, R96 and R496 and had been stored for use at room temperature in the medication carts. LPN-B and LPN-C stated the expired insulin should have instead been removed from the medication carts and placed into the medication storage room for destruction. Later that day two registered nurses (RN)-B and (RN)-C confirmed the Novolog and Lantus were good for only 28 days once they were opened. RN-B and RN-C verified the insulin vials had expired and the expectation was that the expired insulins would have been removed from the medication carts for destruction. A policy and procedure for medication storage was requested, but not provided. The manufacturers' package inserts for Novolog and Lantus insulin verified that any remaining insulin should have been destroyed after 28 days.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		4/22/15

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F 441	Continued From page 45 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the multi-use glucometer (used to measure blood glucose) was disinfected according to acceptable standards to minimize the potential spread of infection for 1 of	F 441	*The multi-use shared glucometer used for R308 has been disinfected according to acceptable standards to minimize the potential spread of infection during blood glucose checks.	

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	245055	A. BUILDING _____ B. WING _____	03/13/2015

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F 441	Continued From page 46 4 residents (R308) who utilized a shared glucometer, and potentially affecting the four residents who shared the glucometer. Findings include: During an observation on 3/11/15, at 11:31 a.m. a licensed practical nurse (LPN)-D went into R308's room to perform her blood glucose check with a glucometer. LPN-D washed her hands, applied gloves, obtained a blood sample via a fingerstick from R308's finger and touched the end of the glucometer stripe to the blood sample. After obtaining the numeric results, LPN-D removed her gloves, washed her hands, put the glucometer back into the basket and returned it to the medication storage room without disinfecting the glucometer before or after it was used. LPN-D then reported she was finished completing R308's blood glucose check. When LPN-D was asked if the glucometer was only used for R308, LPN-D answered, "No, it is used for any resident who requires a blood glucose check." When asked about the proper cleansing of the glucometer, LPN-D stated she cleaned it at the start of her day and before she performed testing on a resident. LPN-E was interviewed on 3/11/15, at 12:34 p.m. and explained that the glucometer was shared between residents. LPN-E stated she expected staff to clean the glucometer with a bleach-based disinfecting wipe after each resident use. A 8/1/13 Blood Glucose Monitoring-Skilled Patient Care Services policy directed staff with step-by-step procedural instructions to clean glucometer "before and after" with a	F 441	*All multi-use glucometers have been disinfected according to acceptable standards to minimize the potential spread of infection during blood glucose checks. *All licensed nursing staff have been educated on proper disinfection of multi-use shared glucometers according to acceptable standards to minimize the spread of infection during blood glucose checks. *Monitoring to ensure compliance will be conducted by the DON or designee through random audits by observing the procedure for blood glucose checks and ensuring all multi-use shared glucometers are disinfected according to the acceptable standards to minimize the potential spread of infection. *The facility QAPI committee will review the results of the blood glucose check observation audits quarterly for further recommendations.	

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WALKER METHODIST HEALTH CENTER	**3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409**

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F 441	Continued From page 47 bleach-based disinfecting wipe to maintain infection control practices.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	**3737 BRYANT AVENUE SOUTH** **MINNEAPOLIS, MN 55409**

(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 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Walker Methodist Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/11/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**03/16/2015**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Walker Methodist Health Center is a 7-story building with a full basement. The building was constructed at 2 different times. The original 5 story building was constructed in 1964 and was determined to be of Type II(222) construction. In 1983, a 7 story addition was constructed to the North that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. This building has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 320 beds and had a census of 312 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 018	Continued From page 2	K 018		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect some residents. Findings include: During facility tour between 10:00 AM and 12:00 PM on 03/16/2015, observation revealed that the corridor doors leading into shower room(s) 5S62, 4S62 and 3S62 do not latch closed.	K 018	*The corridor doors leading into rooms 5S62,4S62, and 3S62 have been fix to latch closed. *All corridor doors leading into shower rooms in the facility latch close. *Maintenance staff have been educated on the requirements for corridor doors to latch. *Monitoring to ensure compliance will be completed by the maintenance supervisor or designee through random audits of the corridor doors' latching function.	4/22/15

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K 018	Continued From page 3 This deficient practice was verified by the maintenance director the time of the inspection.	K 018		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect the residents. Findings include: During facility tour between 10:00 AM and 12:00 PM on 03/16/2015, observation revealed that the resident rooms on 3 Raines are not being used as combustible storage rooms. The doors leading into these rooms do not have door closers. This deficient practice was verified by the maintenance director at the time of the inspection.	K 029	*The resident rooms on 3 Raines being used as storage rooms now have door closers. *All rooms on 3 Raines used as storage rooms have functioning door closers. *Maintenance staff have been educated on the requirement for functioning door closers on the doors to storage rooms. *Monitoring to ensure compliance will be completed by the Maintenance supervisor or designee through random audits of functioning door closers on storage rooms.	4/22/15
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		4/22/15

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K 038 SS=F	Continued From page 4 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 03/16/2015, observation revealed that the back exterior exit leading from the therapy room has chairs, wheelchairs and wall protrusions obstructing the egress path. This deficient practice was verified by the maintenance director at the time of the inspection.	K 038	*The egress path of the back exterior exit leading from the therapy room has been cleared of chairs, wheelchairs and wall protrusions. *All egress paths are clear of obstruction. *All staff have been educated on the requirement for egress paths to be clear of obstruction. *Monitoring to ensure compliance will be completed by the Maintenance supervisor or designee through random audits of egress paths.	