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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 847S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 27996

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245618**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER METHODIST WESTWOOD RIDGE II**
(L4) **61 THOMPSON AVENUE WEST**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

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 **12/05/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (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)
12/31

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

12.Total Facility Beds **37** (L18)
13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
37				
(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 :
Michelle Torrance, HFE NE II 12/24/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/12/2020 (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
11/21/2012
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 16, 2019

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

RE: CCN: 245618
Cycle Start Date: December 5, 2019

Dear Administrator:

On December 5, 2019, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 5, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 5, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	C 12/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/5/2019, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/2/2019 through 12/5/2019, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be NOT SUBSTANTIATED: H5618008C H5618009C H5618010C 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.	F 000		
F 679	Activities Meet Interest/Needs Each Resident	F 679		1/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2019

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F 679 SS=D	Continued From page 1 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to provide activity programming to fit the interests of 2 of 2 residents (R128 and R132) investigated for activities, and one other resident (R125) randomly observed to have missed an activity of interest. Findings include: R128 was observed sitting in his room on 12/2/19, at 2:49 p.m. R128 stated he was bored here. R128 said he had books from home, but he wanted to know what was going on around the facility. There was no calendar of activities observed to be posted anywhere in sight in his room, and R128 did not remember anyone offering him an activity calendar. R128 had admitted recently on 11/24/19, and the care plan initiated on the date of admit did not yet include any information about activity preferences.	F 679	Walker Methodist Westwood Ridge II provides innovative, technically competent, effective, sensitive, individualized, person-centered care and programs. We value the dignity and uniqueness of each individual and strive to maintain their autonomy and independence while providing a safe and secure environment. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest of Facility, its Administrator or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the	

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F 679	Continued From page 2 An Activity Interview for Daily and Activity Preferences dated 11/26/19, noted it was very important for R128 to have books, newspapers, and magazines to read, to keep up with the news, to get outside for fresh air in good weather, and to do things with groups of people. The backside of the Initial Leisure Assessment dated 11/26/19, listed some hand written answers to questions. R128 noted liking to eat with others, and see movies with others. R128 hoped to be able to watch television, read, talk to visitors, and play bingo. R128 liked classical music, and watching sports or the news. During interview on 12/3/19, at 3:29 p.m. the assistant director of life enrichment (ADLE) explained that a weekly calendar of activities was printed and distributed to each room by life enrichment assistants, to let residents know of the programming. ADLE said most of the activities were individual activities, but there were some group activities. On 12/4/19, at 8:34 a.m. the scheduled activities for yesterday were observed to be posted across from the main nursing desk, on the wall outside the activity room. Yesterday's activities included individual activities from the activity cart (games, puzzles, books, etc.), and one on one meetings with the chaplain. On 12/4/19, at 8:41 a.m. R128 was seated in the dining room with a family member (F)-B. R128 and F-B were asked about whether they received a weekly activity schedule brought to the room each week. R128 had not seen it, and F-B said she never saw it, and sometimes visited twice	F 679	correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within 10 days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare program. R125 discharged from the facility on 12/14/19. R128 discharged from the facility on 12/6/19. R132 discharged from the facility on 12/16/19. Risk of re-occurrence will be minimized by the Director of Life Enrichment or designee initiating the following: 1)Whole house audit will be completed to ensure that activity programming meets the activity interests of all residents. 2)Activity calendars will be placed in all resident rooms. New system for documenting attendance of activity programs will be developed and implemented. Education will be completed with life enrichment staff about completing activity programs per the activity calendar. 3)Nursing staff will be educated about making referrals to life enrichment when a resident indicates that they are bored or	

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F 679	Continued From page 3 daily. R128 asked whether the activity programming was posted anywhere, and was surprised to hear it was posted outside the activity room daily. F-B was also unaware that the activity schedule was posted anywhere in the building, and commented that it would have been nice to know, or to have staff come by R128's room and ask if he was interested in the activity that day. F-B explained when R128 first came to the facility, they felt dropped in, and had no clue what went on or who to talk to to find out how things worked around the facility, or that there were activities one could do. F-B never saw any activities going on, and did not know how anyone was supposed to know there was a schedule posted without being told about it. F-B stated, "[R128] has rehab, and then the other 23 hours of the day, you just sit in your room on your bed and watch [television]." F-B stated that was her biggest complaint; there was nothing for R128 to do. A nursing progress note dated 11/29/19, at 3:05 p.m. noted F-B "was very rude and stated 'there is nothing to do here, all [R128] does is sit and be bored.' F-B would not listen when [staff] tried to explain it is a therapy department and most rest after therapies." 12/4/19, at 9:52 a.m. ADLE explained she and one of the life enrichment assistants performed activity assessments, and then indicated interests in the comprehensive care plan when that was due. In a follow up interview at 11:37 a.m. with ADLE and the director of life enrichment (DLE), DLE stated they were working on a better way to track which residents attended which activities. The current activity tracking	F 679	have any concerns about their activity programming. 4)Three audits will be randomly completed weekly to ensure activity programming is meeting the needs of residents. Attendance log will be audited weekly to ensure documentation is complete. 5)Audits will be ongoing until reviewed at QAA monthly and a determination is made that they are no longer necessary.	

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F 679	Continued From page 4	F 679		

system for November and December was reviewed, and R128 was not documented to have participated in any activities during his stay so far. ADLE explained that the leisure cart was brought around room to room once a week, but there was no documentation that R128 took anything from the leisure cart. DLE said the leisure cart going room to room weekly was one way the life enrichment staff could check in with residents, and also if residents or family had concerns about activities, the life enrichment staff needed to know about it to find an activity of interest for them. DLE explained that family might talk to nursing staff about their concerns, and then the expectation was for nursing staff to pass the concerns along to life enrichment staff. Neither DLE, nor ADLE, were aware of the nursing progress note dated 11/29/19, that detailed the activities-related concern R128's family shared with nursing staff. DLE and ADLE stated they would have expected the staff to bring this issue to their attention, and then they would have met with him to try and fix the problem.

R125 admitted to the facility for therapy, and was randomly observed to miss an activity of interest when she was unaware of the activity, and was not asked if she wanted to participate.

On 12/4/19, at approximately 1:40 p.m. life enrichment assistant (LEA)-A stood in the activities room next to a popcorn machine. The smell of popcorn filled the hallways. LEA-A joked that the popcorn made LEA-A popular with the residents, and stated if residents could not come to the activity room for popcorn, then LEA-A would bring a bag of popcorn to their room. At

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F 679	Continued From page 5	F 679		

1:49 p.m. R125 was observed to propel herself in a wheelchair out into the main hallway. R125 commented on how good the air smelled. When asked if she received any popcorn yet, R125 stated, "No, I didn't even know there was popcorn, but then I came out of my room and smelled it." R125 asked, "Where is it?" R125 looked into the activity room to see LEA-A wiping down the popcorn machine and stated, "Looks like it is all gone." LEA-A confirmed it was all gone, and stated she went by R125's room, but R125 was taking a nebulizer at the time. LEA-A finished cleaning the popcorn machine. The weekly activity schedule showed the popcorn activity was not supposed to be over until 2:00 p.m.

R132 admitted 11/7/19 for therapy, and was observed sitting in her room on 12/2/19. During interview at 6:35 p.m. R132 said there was not much to do except turn the television on. R132 stated, "I'm bored to tears." R132 described doing word searches, and had a word search book on her over-the-bed table, but again mentioned there was not much to do and, "It gets boring."

The Initial Leisure Assessment dated 11/13/19, noted that having reading materials, listening to music, keeping up with the news, doing things with groups of people, going outside to get fresh air, and participating in Catholic services were very important to R132. On the back of the assessment was a set of questions and written responses. The responses noted that R132 enjoyed knitting over the past month, and enjoyed playing board games with other people, eating with others, and watching sports and

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F 679	Continued From page 6 movies with others. Review of activity attendance records showed R132 received Catholic Communion once on 11/20/19. Catholic Communion appeared to be offered approximately weekly. Documentation did not include details about whether R132 was offered Communion on other weeks, and chose not to attend, or whether R132 was offered any other activities. The activity calendar showed an average of one to two planned activities each day, along with other activities that were always available on the leisure cart such as games, books, crafts, puzzles, etc. Examples of other activities in the last two weeks included a broadcast worship service, community talk in the activity room, Bingo, popcorn in the activity room, movies, Communion visits, volleyball in the gym, and the room to room leisure cart. There was no documentation about whether R132 was offered these activities. R132's care plan, last revised 11/26/19, noted R132 was independent for meeting emotional, intellectual, and social needs, but was dependent on staff for meeting physical needs related to physical limitations and needing assist from staff with transportation and ambulation using wheelchair and walker. The goal was for R132 to keep involved in cognitive stimulation and social activities as desired. Interventions included providing R132 with materials for individual activities, and assisting R132 to and from activity functions. The care plan noted that preferred activities were word puzzles, reading, listening to music, watching TV, and Catholic Communion. Prior to R132's admission, R132 enjoyed knitting, board games, and watching movies.	F 679		

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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 679	Continued From page 7 On 12/4/19, at 2:03 p.m. R132 said she just had a friend from church bring her Communion over lunch. R132 was very pleased about that, and hoped her friend could keep coming to visit like that.	F 679		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		1/14/20

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	245618	A. BUILDING _____ B. WING _____	C 12/05/2019

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WALKER METHODIST WESTWOOD RIDGE II	**61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118**

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F 755	Continued From page 8 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide ear drop medications in a timely manner for 1 of 1 resident (R174) reviewed for impaired hearing related to cerumen (ear wax) build-up. Findings include: R174's physician order dated 11/26/19, read, "Debrox 10 gtts [drops] each ear daily x [times] 3 days then flush with warm water Dx [Diagnosis] Ceruminosis [Excessive secretion or buildup of cerumen (earwax)]." R174's electronic Medication Administration Record (eMAR) dated 12/1/19 to 12/4/19, included an order for Debrox Solution (Carbamide Peroxide), instill 10 drops in both ears at bedtime for cerumen for 3 Days Perform steps sequentially: 10 drops to affected ear at bedtime x 3 days. Gently irrigate affected ear(s) canal with tepid water on the 3rd day. The eMAR indicated R174 had received the drops 2 times so far this month. When interviewed on 12/2/19, at 1:36 p.m. R174 indicated, had wax (cerumen) build-up in her ears. R174 added, she reported to nursing staff and was told ear drop order was obtained from medical doctor (MD) on 11/26/19. When interviewed on 12/2/19, at 5:27 p.m. family member (F-A) stated, R174 had been	F 755	R174 admitted to facility on 11/18/19. Her ear medication was provided on 12/2/19-12/4/19 and her ears were irrigated on 12/6/19. Physician continues to monitor ear wax build-up and treat accordingly. Resident has participated in all therapy as scheduled. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1)Whole house audit will be completed to ensure there are no medication delivery issues with current orders. 2)Meeting held with pharmacy to review delivery concerns on 12/17/19. Miscommunication on ear medication occurred because the pharmacy thought the medication was part of house stock to be supplied by the facility. Reviewed stock house list that was sent to pharmacy on 4/19/19 that did not list ear medication as house stock. Pharmacy accurately updated their house stock records on 12/4/19. Pharmacy representatives identified staffing challenges on their end that are currently being addressed which will assist with processing orders more accurately and timely.	

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F 755	Continued From page 9 complaining ear plugs for a week now and nothing and been done. F-A further stated, R174 had not been attending therapy due to dizziness from cerumen in her ears. When interviewed on 12/2/19, at 5:55 p.m. licensed practical nurse (LPN)-A verified R174 had an order for debrox 10 drops each ear daily for 3 days, then flush with warm water, dated 11/26/19. LPN-A stated, the order was transcribed in eMAR. LPN-A acknowledged that R174 did not had debrox as ordered because the pharmacy did not delivered the medication. The order had been faxed and called to the pharmacy, and had made the director of nursing aware of the situation. When interviewed on 12/3/19, at 12:43 p.m. DON confirmed R174 had an order for debrox 10 drops each ear daily for 3 days, then flush with warm water, dated 11/26/19. DON stated, pharmacy was contacted several times but pharmacy never delivered it. DON added, the facility does not have debrox in their house stock. When interviewed on 12/3/19, at 3:57 p.m. R174 mentioned staff administered the debrox ear drop last night around 10:00 p.m. and had 2 more days before nursing flush her ears. R174 was dizzy and uncomfortable due to the wax not being removed yet. When interviewed on 12/4/19, at 10:37 a.m. pharmacy consultant (PC) stated debrox is an over the counter drug and the pharmacy thought the facility had it in their house stock. PC indicated, it was a miscommunication between the facility and pharmacy.	F 755	3)Licensed nursing staff will be re-educated on facility policy entitled Medication Orders. 4)Three audits will be randomly completed weekly to ensure there are no medication delivery issues with current orders. 5)Audits will be ongoing until reviewed at QAA monthly and a determination is made that they are no longer necessary.	

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F 755	Continued From page 10 During a telephone interviewed on 12/4/19, at 10:45 a.m. pharmacy manager (PM) point out that the facility called and updated their house stock and this will prevent further miscommunication. PM further stated, pharmacy updated facility house stock on their side. At 11:21 a.m. PM called and indicated their record showed that the facility faxed the order on 11/30/19, not 11/26/19 with a follow-up call from the facility staff on 12/2/19. She stated debrox was delivered to facility on 12/3/19, at 3:00 a.m. When interviewed on 12/5/19, at 1:32 p.m. DON stated, the expectation was staff should fax new orders to pharmacy when they obtained the orders from medical provider via fax with a follow-up call if needed. The facility policy and procedure titled MEDICATION ORDERS, dated 12/7/16, read, "Orders for new medications are faxed to the pharmacy as a direct copy of the prescription order as it is documented in the facility's medical record. If facsimile transmission in not available, the order may be transmitted directly to a pharmacist via phone. All facsimile communications will be signed and dated by licensed nursing staff."	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		1/14/20

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F 880	Continued From page 11 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under	F 880		

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F 880	Continued From page 12 the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow hand hygiene procedures to reduce risk of infection for 2 of 3 residents (R127 and R7) observed during dressing changes. Findings include: R127 was admitted to the facility for surgical aftercare following surgery on the digestive system, per the resident's face sheet, printed 12/5/19. Nurse Practitioner (NP) visit note dated 11/25/19, described R127's abdomen to have a midline	F 880	R7 discharged from facility on 12/4/19. R127 discharged from facility on 12/20/19. Follow-up education completed with RN-A and RN-C. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1)Handwashing Hand Hygiene policy was reviewed and all licensed nursing staff will be re-educated on policy. A hand hygiene during wound care competency checklist will be completed with all	

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F 880	Continued From page 13 incision with staples, with some of the staples from the lower part of the incision removed. The note continued that this part of the abdomen was open, and to be packed with a dressing. The abdominal opening contained a moderate amount of pus. The NP planned for the dressing to be changed twice a day and as needed. During interview on 12/02/19, at 5:32 p.m. R127 described having an infection of the abdominal surgical wound. R127 planned to see a specialist soon about the wound and infection, as the wound was deep, and the doctor was not comfortable packing the wound due to the depth. R127's progress notes dated 11/30/19, described a large amount of pus and malodorous discharge on the dressing and coming from the top of the abdominal incision, which was intact with staples. There was a pin head sized opening that oozed with movement, and the surrounding skin looked inflamed. Another note dated 12/2/19, described the inferior aspect of the wound to have some fat necrosis (dead tissue). R127's care plan dated 12/2/19, noted R127 was on antibiotic therapy related to the surgical wound infection. R127's order dated 11/24/19, required nursing to change the dressing twice daily, with saline dampened gauze packed into the wound, then covered with dry gauze, and then covered by an absorbent pad. R127 had another order dated 12/2/19, for 300 milligrams Clindamycin (antibiotic) three times a day for abdominal wound infection, for ten days.	F 880	licensed nursing staff. 2)Three audits will be randomly completed weekly to ensure proper hand hygiene during wound care. 3)Audits will be ongoing until reviewed at QAA monthly and a determination is made that they are no longer necessary.	

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F 880	Continued From page 14	F 880		

On 12/4/19, at 7:21 a.m. R127 confirmed having an appointment tomorrow morning about the infection. R127 explained being on antibiotics, and said staff swabbed the wound for a culture. R127 stated staff would change the abdominal wound dressing later in the morning.

On 12/4/19, at 10:32 a.m. registered nurse (RN)-C entered R127's room to perform the morning dressing change, while R127 laid on the bed. RN-C prepared the area with needed supplies, used hand sanitizer, and donned gloves. RN-C pulled off the old absorbent pad, which revealed a long surgical incision, mostly closed with staples. There was one opening in the upper part of the incision, and a second opening in the lower part of the incision, where staples had been removed. The openings had been packed with gauze. RN-C pulled the packing out of the openings. The gauze coming out of the wound contained a yellow substance. RN-C threw the gauze in the garbage, removed gloves, and donned new gloves without any hand hygiene. RN-C went to a cabinet in the room, and opened the doors with gloved hands searching for supplies. RN-C came back to the bedside, and wet gauze to clean the skin surrounding the open areas. As RN-C gently pressed down on R127's abdomen with the moistened gauze, a drop of liquid appeared from the lower opening. RN-C stated, "Some pus coming out," as RN-C dabbed the drop of liquid coming from the opening. R127 mentioned feeling tender on the left side of the incision. RN-C threw the gauze in the garbage, and moistened clean gauze. RN-C tried to pack the lower opening, but the gauze fell out, so RN-C threw it in the garbage. RN-C moistened more clean gauze, folded the square

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F 880	Continued From page 15	F 880		

in half, and gently poked it into the opening with her finger. RN-C then packed the upper opening, using a cotton swab to push the packing inside. RN-C changed gloves again, without any hand hygiene. RN-C finished the dressing by laying clean square gauze on top of the packed openings, and then laying absorbent pads on top of the entire area, before taping it down to R127's skin. R127 tucked a wash cloth into the pants waistband, commenting that "it sometimes drips a little." RN-C removed gloves, and used alcohol based hand rub before leaving the room at 10:45 a.m.

In a follow-up interview on 12/4/19, at 10:55 a.m. RN-C was asked about hand hygiene practices, and confirmed missing a hand hygiene opportunity. RN-C stated staff were supposed to wash hands with soap and water after removing a dirty dressing, before putting gloves back on to put on a clean dressing. RN-C described knowing what to do, but forgetting to do it. RN-C stated R127's abdominal wound did have some yellow pus that was slowly seeping out a little from each open area, and commented that staff collected a sample from the wound for culture.

On 12/4/19, laboratory results showed Coagulase positive Staphylococcus (a type of bacteria) was growing in the wounds.

R7 was admitted to the facility for surgical aftercare following surgery on the skin and subcutaneous tissue, per the resident's face sheet, printed 12/4/19.

During interview on 12/02/19, at 7:34 p.m. R7

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F 880	Continued From page 16	F 880		

described having a sore on his coccyx, with a wound vac (Vacuum assisted closure of a wound, by using a device to decrease the air pressure on the wound).

The care plan dated 11/13/19, noted R7 was on antibiotic therapy related to recent infection and surgery.

An order dated 10/24/19, required nursing to change the KCl (brand name) wound vac to left buttock wound 3x/week. Every Monday, Wednesday and Friday. The setting for the wound vac was negative pressure of 125 mmHG continuous, delivering pressure for 22 out of 24 hours. "If the pump alarms, try to locate the leak, cover with Tegaderm. If the seal cannot be maintained for 2 hrs (hours), remove vac dressing, replace with NS (normal saline) wet to moist dressing and notify MD." R7 had another order dated 11/19/19, for Zosyn Solution (antibiotic) Reconstituted 3.375 GM (grams) intravenously every 6 hours for Nercotizing Fascitis (dying tissue) until 12/3/19 11:59 p.m.

On 12/4/19, at 1:43 a.m. registered nurse (RN)-A entered R7's room to perform the dressing change, while R7 laid on the bed. RN-A prepared the area with needed supplies, washed hands , and donned gloves. RN-A pulled off the wound vac dressing , which revealed a deep open wound. The opening had been packed with wound vac foam. RN-A pulled the foam out of the opening. RN-A threw the foam and dressing in the garbage. RN-A cut new foam to fit the opening, without changing gloves, applied skin prep around the foam and applied the adhesive sheet over, removed gloves, and donned new

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F 880	Continued From page 17	F 880		

gloves without any hand hygiene. RN-A went to a cabinet in the room, and opened the doors with gloved hands searching for supplies. RN-A came back to the bedside, and completed taping the wound vac tube to the dressing.

In a follow-up interview on 12/4/19, at 2:05 p.m. RN-A was asked about hand hygiene practices, and confirmed missing some hand hygiene opportunities. RN-A stated he should have changed his gloves and washed his hands more often.

An interview with RN-B (infection control nurse) on 12/4/19, at 2:15 p.m. she verified staff should perform hand hygiene after removing gloves and change gloves after removing a dressing.

The facilities Hand Hygiene Policy dated 2007 indicated the following:
1. b. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such, and before eating and after using the restroom.
c. Wash hands after removing gloves.
2. e. Change gloves, as necessary, during the care of a resident to prevent cress-contamination from one body site to another (when moving from a "dirty" site to a "clean" one.)
g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments

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K 000	INITIAL COMMENTS 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. OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Walker Methodist Westwood Ridge II was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2019

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

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WALKER METHODIST WESTWOOD RIDGE II	**61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118**

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K 000	Continued From page 1 Code (LSC) Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN to: FM.HC.Inspections@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 Westwood Ridge II is a 1-story building with a partial basement. The facility was constructed in 2012 and was determined to be of Type V(111) construction. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridors and is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls	K 362		1/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**12/04/2019**

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K 362	Continued From page 2 constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to Maintain Corridors - Construction of Walls in accordance with (NFPA 101 / NFPA 99), (Life Safety Code / Health Care Facilities Code), Section 19.3.6.2, 19.3.6.2.7. This deficient practice could affect 37 of residents. Findings include: On a facility tour between the hours of 9-1 PM on 12/4/2019, it was revealed that we found a Penetration in the smoke barrier wall by the kitchen area. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 362	The penetration in the smoke barrier wall by the kitchen area will be repaired. A whole house audit will be completed to ensure the integrity of all smoke barriers. Director of Environmental Services or designee is responsible for correction and monitoring to prevent re-occurrence.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K 923		1/14/20

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K 923	Continued From page 3 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to Maintain Gas Equipment - Cylinder and Container Storage in accordance	K 923	Signs will be placed in oxygen storage room indicating full and empty for proper storage of oxygen cylinders. Director of	

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K 923	Continued From page 4 with (NFPA 101 / NFPA 99), (Life Safety Code / Health Care Facilities Code), Section 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99). This deficient practice could affect 37 of residents. Findings include: On a facility tour between the hours of (9-1pm) on 12/4/2019, it was revealed that we found the Oxygen storage room isn't marked full and empty cylinders on the wall. The K type cylinders are mixed together in the room. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 923	Environmental Services or designee is responsible for correction and monitoring to prevent re-occurrence.	

Electronically delivered
December 16, 2019

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

Re: State Nursing Home Licensing Orders
Event ID: 847S11

Dear Administrator:

The above facility was surveyed on December 2, 2019 through December 5, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF

CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794

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

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.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27996	A. BUILDING: _____ B. WING _____	C 12/05/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/2/19 through 12/5/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. The following complaints were also investigated and found not to be substantiated: H5618008C	2 000		

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2 000	Continued From page 1 H5618009C H5618010C The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow hand hygiene procedures to reduce risk of infection for 2 of 3 residents (R127, R7) observed during dressing changes. Findings include: R127 was admitted to the facility for surgical aftercare following surgery on the digestive system, per the resident's face sheet, printed 12/5/19. Nurse Practitioner (NP) visit note dated 11/25/19, described R127's abdomen to have a midline incision with staples, with some of the staples from the lower part of the incision removed. The note continued that this part of the abdomen was open, and to be packed with a dressing. The abdominal opening contained a moderate amount of pus. The NP planned for the dressing to be changed twice a day and as needed.	21375	Corrected.	1/14/20

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21375	Continued From page 3 During interview on 12/02/19, at 5:32 p.m. R127 described having an infection of the abdominal surgical wound. R127 planned to see a specialist soon about the wound and infection, as the wound was deep, and the doctor was not comfortable packing the wound due to the depth. R127's progress notes dated 11/30/19, described a large amount of pus and malodorous discharge on the dressing and coming from the top of the abdominal incision, which was intact with staples. There was a pin head sized opening that oozed with movement, and the surrounding skin looked inflamed. Another note dated 12/2/19, described the inferior aspect of the wound to have some fat necrosis (dead tissue). R127's care plan dated 12/2/19, noted R127 was on antibiotic therapy related to the surgical wound infection. R127's order dated 11/24/19, required nursing to change the dressing twice daily, with saline dampened gauze packed into the wound, then covered with dry gauze, and then covered by an absorbent pad. R127 had another order dated 12/2/19, for 300 milligrams Clindamycin (antibiotic) three times a day for abdominal wound infection, for ten days. On 12/4/19, at 7:21 a.m. R127 confirmed having an appointment tomorrow morning about the infection. R127 explained being on antibiotics, and said staff swabbed the wound for a culture. R127 stated staff would change the abdominal wound dressing later in the morning. On 12/4/19, at 10:32 a.m. registered nurse	21375		

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21375	Continued From page 4 (RN)-C entered R127's room to perform the morning dressing change, while R127 laid on the bed. RN-C prepared the area with needed supplies, used hand sanitizer, and donned gloves. RN-C pulled off the old absorbent pad, which revealed a long surgical incision, mostly closed with staples. There was one opening in the upper part of the incision, and a second opening in the lower part of the incision, where staples had been removed. The openings had been packed with gauze. RN-C pulled the packing out of the openings. The gauze coming out of the wound contained a yellow substance. RN-C threw the gauze in the garbage, removed gloves, and donned new gloves without any hand hygiene. RN-C went to a cabinet in the room, and opened the doors with gloved hands searching for supplies. RN-C came back to the bedside, and wet gauze to clean the skin surrounding the open areas. As RN-C gently pressed down on R127's abdomen with the moistened gauze, a drop of liquid appeared from the lower opening. RN-C stated, "Some pus coming out," as RN-C dabbed the drop of liquid coming from the opening. R127 mentioned feeling tender on the left side of the incision. RN-C threw the gauze in the garbage, and moistened clean gauze. RN-C tried to pack the lower opening, but the gauze fell out, so RN-C threw it in the garbage. RN-C moistened more clean gauze, folded the square in half, and gently poked it into the opening with her finger. RN-C then packed the upper opening, using a cotton swab to push the packing inside. RN-C changed gloves again, without any hand hygiene. RN-C finished the dressing by laying clean square gauze on top of the packed openings, and then laying absorbent pads on top of the entire area, before taping it down to R127's skin. R127 tucked a wash cloth into the pants	21375		

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21375	Continued From page 5	21375		

waistband, commenting that "it sometimes drips a little." RN-C removed gloves, and used alcohol based hand rub before leaving the room at 10:45 a.m.

In a follow-up interview on 12/4/19, at 10:55 a.m. RN-C was asked about hand hygiene practices, and confirmed missing a hand hygiene opportunity. RN-C stated staff were supposed to wash hands with soap and water after removing a dirty dressing, before putting gloves back on to put on a clean dressing. RN-C described knowing what to do, but forgetting to do it. RN-C stated R127's abdominal wound did have some yellow pus that was slowly seeping out a little from each open area, and commented that staff collected a sample from the wound for culture.

On 12/4/19, laboratory results showed Coagulase positive Staphylococcus (a type of bacteria) was growing in the wounds.

R7 was admitted to the facility for surgical aftercare following surgery on the skin and subcutaneous tissue, per the resident's face sheet, printed 12/4/19.

During interview on 12/02/19, at 7:34 p.m. R7 described having a sore on his coccyx, with a wound vac (Vacuum assisted closure of a wound, by using a device to decrease the air pressure on the wound).

The care plan dated 11/13/19, noted R7 was on antibiotic therapy related to recent infection and surgery.

An order dated 10/24/19, required nursing to change the KCI (brand name) wound vac to left

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21375	Continued From page 6	21375		

buttock wound 3x/week. Every Monday, Wednesday and Friday. The setting for the wound vac was negative pressure of 125 mmHG continuous, delivering pressure for 22 out of 24 hours. "If the pump alarms, try to locate the leak, cover with Tegaderm. If the seal cannot be maintained for 2 hrs (hours), remove vac dressing, replace with NS (normal saline) wet to moist dressing and notify MD." R7 had another order dated 11/19/19, for Zosyn Solution (antibiotic) Reconstituted 3.375 GM (grams) intravenously every 6 hours for Nercotizing Fascitis (dying tissue) until 12/3/19 11:59 p.m.

On 12/4/19, at 1:43 a.m. registered nurse (RN)-A entered R7's room to perform the dressing change, while R7 laid on the bed. RN-A prepared the area with needed supplies, washed hands , and donned gloves. RN-A pulled off the wound vac dressing , which revealed a deep open wound. The opening had been packed with wound vac foam. RN-A pulled the foam out of the opening. RN-A threw the foam and dressing in the garbage. RN-A cut new foam to fit the opening, without changing gloves, applied skin prep around the foam and applied the adhesive sheet over, removed gloves, and donned new gloves without any hand hygiene. RN-A went to a cabinet in the room, and opened the doors with gloved hands searching for supplies. RN-A came back to the bedside, and completed taping the wound vac tube to the dressing.

In a follow-up interview on 12/4/19, at 2:05 p.m. RN-A was asked about hand hygiene practices, and confirmed missing some hand hygiene opportunities. RN-A stated he should have changed his gloves and washed his hands more often.

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21375	Continued From page 7 An interview with RN-B (infection control nurse) on 12/4/19, at 2:15 p.m. she verified staff should perform hand hygiene after removing gloves and change gloves after removing a dressing. The facilities Hand Hygiene Policy dated 2007 indicated the following: 1. b. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such, and before eating and after using the restroom. c. Wash hands after removing gloves. 2. e. Change gloves, as necessary, during the care of a resident to prevent cress-contamination from one body site to another (when moving from a "dirty" site to a "clean" one.) g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures and educate the appropriate staff on the policies/procedures for hand hygiene and glove use during personal cares, hand hygiene during cares when infection is suspected, and when the resident is vulnerable to infection. DON or designee could implement a surveillance program for the facility. The DON or designee could develop a monitoring system to ensure ongoing compliance.	21375		

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21375	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the facility failed to provide activity programming to fit the interests of 2 of 2 residents (R128 and R132) investigated for activities, and one other resident (R125) randomly observed to have missed an activity of interest. Findings include: R128 was observed sitting in his room on 12/2/19, at 2:49 p.m. R128 stated he was bored here. R128 said he had books from home, but he wanted to know what was going on around the facility. There was no calendar of activities observed to be posted anywhere in sight in his	21435	Corrected.	1/14/20

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room, and R128 did not remember anyone offering him an activity calendar.

R128 had admitted recently on 11/24/19, and the care plan initiated on the date of admit did not yet include any information about activity preferences.

An Activity Interview for Daily and Activity Preferences dated 11/26/19, noted it was very important for R128 to have books, newspapers, and magazines to read, to keep up with the news, to get outside for fresh air in good weather, and to do things with groups of people. The backside of the Initial Leisure Assessment dated 11/26/19, listed some hand written answers to questions. R128 noted liking to eat with others, and see movies with others. R128 hoped to be able to watch television, read, talk to visitors, and play bingo. R128 liked classical music, and watching sports or the news.

During interview on 12/3/19, at 3:29 p.m. the assistant director of life enrichment (ADLE) explained that a weekly calendar of activities was printed and distributed to each room by life enrichment assistants, to let residents know of the programming. ADLE said most of the activities were individual activities, but there were some group activities.

On 12/4/19, at 8:34 a.m. the scheduled activities for yesterday were observed to be posted across from the main nursing desk, on the wall outside the activity room. Yesterday's activities included individual activities from the activity cart (games, puzzles, books, etc.), and one on one meetings with the chaplain.

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21435	Continued From page 10 On 12/4/19, at 8:41 a.m. R128 was seated in the dining room with a family member (F)-B. R128 and F-B were asked about whether they received a weekly activity schedule brought to the room each week. R128 had not seen it, and F-B said she never saw it, and sometimes visited twice daily. R128 asked whether the activity programming was posted anywhere, and was surprised to hear it was posted outside the activity room daily. F-B was also unaware that the activity schedule was posted anywhere in the building, and commented that it would have been nice to know, or to have staff come by R128's room and ask if he was interested in the activity that day. F-B explained when R128 first came to the facility, they felt dropped in, and had no clue what went on or who to talk to to find out how things worked around the facility, or that there were activities one could do. F-B never saw any activities going on, and did not know how anyone was supposed to know there was a schedule posted without being told about it. F-B stated, "[R128] has rehab, and then the other 23 hours of the day, you just sit in your room on your bed and watch [television]." F-B stated that was her biggest complaint; there was nothing for R128 to do. A nursing progress note dated 11/29/19, at 3:05 p.m. noted F-B "was very rude and stated 'there is nothing to do here, all [R128] does is sit and be bored.' F-B would not listen when [staff] tried to explain it is a therapy department and most rest after therapies." 12/4/19, at 9:52 a.m. ADLE explained she and one of the life enrichment assistants performed activity assessments, and then indicated interests in the comprehensive care plan when	21435		

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that was due. In a follow up interview at 11:37 a.m. with ADLE and the director of life enrichment (DLE), DLE stated they were working on a better way to track which residents attended which activities. The current activity tracking system for November and December was reviewed, and R128 was not documented to have participated in any activities during his stay so far. ADLE explained that the leisure cart was brought around room to room once a week, but there was no documentation that R128 took anything from the leisure cart. DLE said the leisure cart going room to room weekly was one way the life enrichment staff could check in with residents, and also if residents or family had concerns about activities, the life enrichment staff needed to know about it to find an activity of interest for them. DLE explained that family might talk to nursing staff about their concerns, and then the expectation was for nursing staff to pass the concerns along to life enrichment staff. Neither DLE, nor ADLE, were aware of the nursing progress note dated 11/29/19, that detailed the activities-related concern R128's family shared with nursing staff. DLE and ADLE stated they would have expected the staff to bring this issue to their attention, and then they would have met with him to try and fix the problem.

R125 admitted to the facility for therapy, and was randomly observed to miss an activity of interest when she was unaware of the activity, and was not asked if she wanted to participate.

On 12/4/19, at approximately 1:40 p.m. life enrichment assistant (LEA)-A stood in the activities room next to a popcorn machine. The smell of popcorn filled the hallways. LEA-A joked

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that the popcorn made LEA-A popular with the residents, and stated if residents could not come to the activity room for popcorn, then LEA-A would bring a bag of popcorn to their room. At 1:49 p.m. R125 was observed to propel herself in a wheelchair out into the main hallway. R125 commented on how good the air smelled. When asked if she received any popcorn yet, R125 stated, "No, I didn't even know there was popcorn, but then I came out of my room and smelled it." R125 asked, "Where is it?" R125 looked into the activity room to see LEA-A wiping down the popcorn machine and stated, "Looks like it is all gone." LEA-A confirmed it was all gone, and stated she went by R125's room, but R125 was taking a nebulizer at the time. LEA-A finished cleaning the popcorn machine. The weekly activity schedule showed the popcorn activity was not supposed to be over until 2:00 p.m.

R132 admitted 11/7/19 for therapy, and was observed sitting in her room on 12/2/19. During interview at 6:35 p.m. R132 said there was not much to do except turn the television on. R132 stated, "I'm bored to tears." R132 described doing word searches, and had a word search book on her over-the-bed table, but again mentioned there was not much to do and, "It gets boring."

The Initial Leisure Assessment dated 11/13/19, noted that having reading materials, listening to music, keeping up with the news, doing things with groups of people, going outside to get fresh air, and participating in Catholic services were very important to R132. On the back of the assessment was a set of questions and written responses. The responses noted that R132

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enjoyed knitting over the past month, and enjoyed playing board games with other people, eating with others, and watching sports and movies with others.

Review of activity attendance records showed R132 received Catholic Communion once on 11/20/19. Catholic Communion appeared to be offered approximately weekly. Documentation did not include details about whether R132 was offered Communion on other weeks, and chose not to attend, or whether R132 was offered any other activities. The activity calendar showed an average of one to two planned activities each day, along with other activities that were always available on the leisure cart such as games, books, crafts, puzzles, etc. Examples of other activities in the last two weeks included a broadcast worship service, community talk in the activity room, Bingo, popcorn in the activity room, movies, Communion visits, volleyball in the gym, and the room to room leisure cart. There was no documentation about whether R132 was offered these activities.

R132's care plan, last revised 11/26/19, noted R132 was independent for meeting emotional, intellectual, and social needs, but was dependent on staff for meeting physical needs related to physical limitations and needing assist from staff with transportation and ambulation using wheelchair and walker. The goal was for R132 to keep involved in cognitive stimulation and social activities as desired. Interventions included providing R132 with materials for individual activities, and assisting R132 to and from activity functions. The care plan noted that preferred activities were word puzzles, reading, listening to music, watching TV, and Catholic Communion.

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21435	Continued From page 14 Prior to R132's admission, R132 enjoyed knitting, board games, and watching movies. On 12/4/19, at 2:03 p.m. R132 said she just had a friend from church bring her Communion over lunch. R132 was very pleased about that, and hoped her friend could keep coming to visit like that. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure all residents received a comprehensive activity assessment to assist with developing individualized, resident centered interventions. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to provide ear drop medications in a timely manner for 1 of 1 resident (R174) reviewed for impaired hearing related to cerumen	21550	Corrected.	1/14/20

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21550	Continued From page 15 (ear wax) build-up. Findings include: R174's physician order dated 11/26/19, read, "Debrox 10 gtts [drops] each ear daily x [times] 3 days then flush with warm water Dx [Diagnosis] Ceruminosis [Excessive secretion or buildup of cerumen (earwax)]." R174's electronic Medication Administration Record (eMAR) dated 12/1/19 to 12/4/19, included an order for Debrox Solution (Carbamide Peroxide), instill 10 drops in both ears at bedtime for cerumen for 3 Days Perform steps sequentially: 10 drops to affected ear at bedtime x 3 days. Gently irrigate affected ear(s) canal with tepid water on the 3rd day. The eMAR indicated R174 had received the drops 2 times so far this month. When interviewed on 12/2/19, at 1:36 p.m. R174 indicated, had wax (cerumen) build-up in her ears. R174 added, she reported to nursing staff and was told ear drop order was obtained from medical doctor (MD) on 11/26/19. When interviewed on 12/2/19, at 5:27 p.m. family member (F-A) stated, R174 had been complaining ear plugs for a week now and nothing and been done. F-A further stated, R174 had not been attending therapy due to dizziness from cerumen in her ears. When interviewed on 12/2/19, at 5:55 p.m. licensed practical nurse (LPN)-A verified R174 had an order for debrox 10 drops each ear daily for 3 days, then flush with warm water, dated 11/26/19. LPN-A stated, the order was	21550		

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transcribed in eMAR. LPN-A acknowledged that R174 did not had debrox as ordered because the pharmacy did not delivered the medication. The order had been faxed and called to the pharmacy, and had made the director of nursing aware of the situation.

When interviewed on 12/3/19, at 12:43 p.m. DON confirmed R174 had an order for debrox 10 drops each ear daily for 3 days, then flush with warm water, dated 11/26/19. DON stated, pharmacy was contacted several times but pharmacy never delivered it. DON added, the facility does not have debrox in their house stock.

When interviewed on 12/3/19, at 3:57 p.m. R174 mentioned staff administered the debrox ear drop last night around 10:00 p.m. and had 2 more days before nursing flush her ears. R174 was dizzy and uncomfortable due to the wax not being removed yet.

When interviewed on 12/4/19, at 10:37 a.m. pharmacy consultant (PC) stated debrox is an over the counter drug and the pharmacy thought the facility had it in their house stock. PC indicated, it was a miscommunication between the facility and pharmacy.

During a telephone interviewed on 12/4/19, at 10:45 a.m. pharmacy manager (PM) point out that the facility called and updated their house stock and this will prevent further miscommunication. PM further stated, pharmacy updated facility house stock on their side. At 11:21 a.m. PM called and indicated their record showed that the facility faxed the order on 11/30/19, not 11/26/19 with a follow-up call from the facility staff on 12/2/19. She stated debrox

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21550	Continued From page 17 was delivered to facility on 12/3/19, at 3:00 a.m. When interviewed on 12/5/19, at 1:32 p.m. DON stated, the expectation was staff should fax new orders to pharmacy when they obtained the orders from medical provider via fax with a follow-up call if needed. The facility policy and procedure titled MEDICATION ORDERS, dated 12/7/16, read, "Orders for new medications are faxed to the pharmacy as a direct copy of the prescription order as it is documented in the facility's medical record. If facsimile transmission in not available, the order may be transmitted directly to a pharmacist via phone. All facsimile communications will be signed and dated by licensed nursing staff." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and pharmacist or their designee, could develop, review/revise and implement policies/procedures and staff training related to assurance that the medication needs of each resident are met in a timely manner. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		