DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITT	AL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGEN	CY

Facility ID: 27996

MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY						4	E . CETON	2 (7.0)	
1. MEDICARE/MEDICAID PROVIDE (L1) 245618	ER NO.	(L3) WALKER M			OD RIDGE II		4. TYPE O	F ACTION:	<u>2 (</u> L8)
2.STATE VENDOR OR MEDICAID N	IO	(L4) 61 THOMPS			OD KIDGE II		1. Initial		2. Recertification
(L2)	.0.	(L5) WEST SAIN		***************************************	(L6) 5	5118	3. Termin 5. Validat		4. CHOW 6. Complaint
							7. On-Site		9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	DWNERSHIP	7. PROVIDER/SU 01 Hospital	OF HHA	ORY 09 ESRD	<u>04</u> (L7) 13 PTIP	22 CLIA	8. Full Su	rvey After Con	nplaint
6. DATE OF SURVEY 12/05	5/ 2019 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF				
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEA	AR ENDING I	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/	/31	
11LTC PERIOD OF CERTIFICATION	ı	10.THE FACILITY	' IS CERTIFIED	AS:					
From (a):		A. In Complia	nce With		And/Or Approve	ed Waivers Of T	The Following R	Requirements:	
To (b):			equirements		2. Techn	ical Personnel	_ 6. Sc	ope of Service	es Limit
		Compliance	e Based On:		3. 24 Ho	our RN	7. Me	edical Directo	or
12.Total Facility Beds	37 (L18)	1. A	cceptable POC		4. 7-Day	RN (Rural SN	F) 8. Pa	tient Room Siz	ze
13. Total Certified Beds	37 (L17)	X B. Not in Con	anlianaa with Dra	780.00	5. Life S	afety Code	9. Be	eds/Room	
13. Total Certified Beds	07 (E17)		and/or Applied \		* Code: B	*	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN	_			15. FACILITY M	EETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1	1861 (j) (1):	(L	15)	
37					() ()	U , ()			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):					
				,					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	/EY AGENCY	APPROVAL		Date:
Mishalla Tamana	LIEE NE II	4	2/24/2010						
Michelle Torrance,	HFE NE II	1	2/24/2019	(L19)	Kamala Fiske	-Downing, Er	nforcement S	pecialist	01/12/2020 (L20)
		COMPLETED I		` ′					
	RT II - TO BE (COMPLETED I	BY HCFA RE	EGIONAL	21. 1. Sta	SINGLE ST	FATE AGEN	NCY ICFA-2572)	(L20)
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Protecting, Maintaining and Improving the Health of All Minnesotans

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

M. Pais

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 12/24/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245618	B. WING		C 12/05/2019
	PROVIDER OR SUPPLIER	VOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118	1270072010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
E 000	Initial Comments		E 000		
F 000	Emergency Prepare conducted on 12/5/		F 000		
	survey was conductinvestigations were was found not to be federal requirement	ugh 12/5/2019, a standard ted at your facility. Complaint also conducted. Your facility in compliance with the ts of 42 CFR 483, Subpart B, ong Term Care Facilities.			
	The following comp SUBSTANTIATED:	laints were found to be NOT			
	H5618008C H5618009C H5618010C				
	as your allegation of Department's accepenrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required if first page of the CMS-2567 ic submission of the POC will tion of compliance.			
	an on-site revisit of conducted to valida with the regulations accordance with yo				
		rest/Needs Each Resident	F 679		1/14/20
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245618	B. WING) 05/2019
	PROVIDER OR SUPPLIER	VOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 679 SS=D	CFR(s): 483.24(c)(§483.24(c) Activities §483.24(c)(1) The fithe comprehensive and the preference program to support activities, both facili individual activities designed to meet th physical, mental, an each resident, enco and interaction in the This REQUIREMEN by: Based on interview review, the facility fit programming to fit the residents (R128 an activities, and one or randomly observed interest. Findings include: R128 was observed 12/2/19, at 2:49 p.m. here. R128 said he wanted to know wh facility. There was r observed to be pos	s. facility must provide, based on assessment and care plan so feach resident, an ongoing residents in their choice of ity-sponsored group and and independent activities, he interests of and support the nd psychosocial well-being of ouraging both independence he community. NT is not met as evidenced w, observation, and record ailed to provide activity the interests of 2 of 2 d R132) investigated for other resident (R125) to have missed an activity of d sitting in his room on n. R128 stated he was bored had books from home, but he at was going on around the no calendar of activities ted anywhere in sight in his d not remember anyone	F 679	Walker Methodist Westwood Ridge provides innovative, technically competent, effective, sensitive, individualized, person-centered car programs. We value the dignity an uniqueness of each individual and to maintain their autonomy and independence while providing a sa secure environment. Submission of Credible Allegation of Compliance legal admission that a deficiency we correctly cited, and is also not to be construed as an admission against interest of Facility, its Administrator employees, agents, or other individual of Credible Allegation of Compliance.	re and d strive fe and of this is not a xists or as e cor any luals nis In	
		recently on 11/24/19, and the on the date of admit did not yet ation about activity		addition, preparation and submission the Credible Allegation of Compliar does not constitute an admission of agreement of any kind by Facility of truth of any facts alleged or the	nce r	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245618	B. WING		12/0)5/2019	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (.0.2010	
WALKER	METHODIST WEST	WOOD RIDGE II		61 THOMPSON AVENUE WEST			
WALKLI	WETHODIST WEST	WOOD RIDGE II		WEST SAINT PAUL, MN 55118			
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F 679	An Activity Intervier Preferences dated important for R128 and magazines to news, to get outsid and to do things with backside of the Init 11/26/19, listed sort questions. R128 not and see movies with able to watch televial play bingo. R128 literation watching sports or During interview or assistant director of explained that a well-printed and distribute enrichment assistant the programming. An activities were indivisome group activities on 12/4/19, at 8:32 for yesterday were from the main nurse the activity room. Yindividual activities puzzles, books, etc. With the chaplain. On 12/4/19, at 8:42 dining room with a and F-B were asked a weekly activity so	w for Daily and Activity 11/26/19, noted it was very to have books, newspapers, read, to keep up with the le for fresh air in good weather, ith groups of people. The tial Leisure Assessment dated me hand written answers to oted liking to eat with others, th others. R128 hoped to be ision, read, talk to visitors, and ked classical music, and the news. 112/3/19, at 3:29 p.m. the of life enrichment (ADLE) eekly calendar of activities was uted to each room by life ants, to let residents know of ADLE said most of the vidual activities, but there were ies. 4 a.m. the scheduled activities observed to be posted across sing desk, on the wall outside vesterday's activities included from the activity cart (games, c.), and one on one meetings 1 a.m. R128 was seated in the family member (F)-B. R128 ed about whether they received chedule brought to the room	F 6	correctness of any conclust this allegation by the surver Accordingly, we are submit Credible Allegation of Combecause state and federal submission of a Credible A Compliance within 10 days the Statement of Deficiency condition to participate in the program. R125 discharged from the 12/14/19. R128 discharged from the 12/6/19. R132 discharged from the 12/16/19. R132 discharged from the 12/16/19. Also of re-occurrence will be by the Director of Life Enricedesignee initiating the following the activity interests of all resident rooms. New system documenting attendance of programs will be developed implemented. Education we completed with life enriching completing activity programactivity calendar. 3) Nursing staff will be education.	ey agency. tting this appliance solely law mandate allegation of s of receipt of sies as a he Medicare facility on facility on facility on facility on oe minimized chment or awing: e completed to aming meets residents. placed in all em for activity d and will be nent staff about as per the		
	each week. R128 h	nad not seen it, and F-B said and sometimes visited twice		making referrals to life enri resident indicates that they	ichment when a		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			61	TREET ADDRESS, CITY, STATE, ZIP CODE THOMPSON AVENUE WEST VEST SAINT PAUL, MN 55118	1 12/	50/2010
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F 679	daily. R128 asked programming was surprised to hear it activity room daily. the activity schedu building, and commice to know, or to room and ask if he that day. F-B explathe facility, they fel what went on or withings worked arouwere activities one activities going on, was supposed to k posted without bein "[R128] has rehab, of the day, you just and watch [televisi biggest complaint; do. A nursing progress p.m. noted F-B "wais nothing to do he bored.' F-B would explain it is a thera after therapies." 12/4/19, at 9:52 a. one of the life enricactivity assessment interests in the contact was due. In a a.m. with ADLE an enrichment (DLE), on a better way to	whether the activity posted anywhere, and was a was posted outside the F-B was also unaware that le was posted anywhere in the mented that it would have been have staff come by R128's was interested in the activity ained when R128 first came to t dropped in, and had no clue ho to talk to to find out how and the facility, or that there could do. F-B never saw any and did not know how anyone mow there was a schedule ng told about it. F-B stated, and then the other 23 hours there was nothing for R128 to as very rude and stated 'there re, all [R128] does is sit and be not listen when [staff] tried to apy department and most rest m. ADLE explained she and chment assistants performed ats, and then indicated mprehensive care plan when follow up interview at 11:37 d the director of life DLE stated they were working track which residents attended are current activity tracking	F 6	379	have any concerns about their acti programming. 4)Three audits will be randomly completed weekly to ensure activit programming is meeting the needs residents. Attendance log will be a weekly to ensure documentation is complete. 5)Audits will be ongoing until review QAA monthly and a determination made that they are no longer nece	y s of audited s wed at is	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 679	system for Novem reviewed, and R12 have participated so far. ADLE explabrought around rothere was no doct anything from the leisure cart going way the life enrich residents, and also concerns about an needed to know a interest for them. It talk to nursing state the concerns alon Neither DLE, nor an ursing progress of detailed the activitifamily shared with stated they would bring this issue to would have met we problem. R125 admitted to randomly observe when she was unanot asked if she we on 12/4/19, at appenrichment assisting activities room nessell of popcorn from that the popcorn from residents, and state to the activity room.	age 4 aber and December was 28 was not documented to in any activities during his stay ained that the leisure cart was om to room once a week, but amentation that R128 took leisure cart. DLE said the room to room weekly was one ment staff could check in with original or family had ctivities, the life enrichment staff bout it to find an activity of DLE explained that family might of about their concerns, and on was for nursing staff to pass good to life enrichment staff. ADLE, were aware of the note dated 11/29/19, that ties-related concern R128's nursing staff. DLE and ADLE have expected the staff to their attention, and then they with him to try and fix the staff to the facility for therapy, and was do to miss an activity of interest aware of the activity, and was anted to participate. Droximately 1:40 p.m. life ant (LEA)-A stood in the activity and was anted to participate. Droximately 1:40 p.m. life ant (LEA)-A stood in the activity and was anted to participate. Droximately 1:40 p.m. life ant (LEA)-A stood in the activity and was anted to participate. Droximately 1:40 p.m. life ant (LEA)-A stood in the activity and was anted to participate. Droximately 1:40 p.m. life ant (LEA)-A stood in the activity and was anted to participate. Droximately 1:40 p.m. life ant (LEA)-A stood in the activity and was anted to participate.	F 6	779			

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F 679	1:49 p.m. R125 wa a wheelchair out in commented on how asked if she receiv stated, "No, I didn't popcorn, but then I smelled it." R125 a looked into the actidown the popcorn like it is all gone." L gone, and stated s R125 was taking a finished cleaning the weekly activity scheactivity was not supp.m. R132 admitted 11/7 observed sitting in interview at 6:35 p. much to do except stated, "I'm bored the doing word searchebook on her over-the mentioned there we boring." The Initial Leisure whoring." The Initial Leisure whoring." The Initial Leisure whoring. The initial Leisure whoring. The initial Leisure whoring. The initial Leisure whoring are sponses. The resenjoyed knitting overnjoyed playing borenjoyed playing borening.	age 5 as observed to propel herself in to the main hallway. R125 a good the air smelled. When ed any popcorn yet, R125 a even know there was came out of my room and sked, "Where is it?" R125 by vity room to see LEA-A wiping machine and stated, "Looks LEA-A confirmed it was all he went by R125's room, but nebulizer at the time. LEA-A ne popcorn machine. The edule showed the popcorn opposed to be over until 2:00 7/19 for therapy, and was her room on 12/2/19. During m. R132 said there was not turn the television on. R132 o tears." R132 described es, and had a word search ne-bed table, but again as not much to do and, "It gets Assessment dated 11/13/19, eading materials, listening to with the news, doing things ple, going outside to get fresh ag in Catholic services were than C	F 67	79		

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F 679	movies with others. Review of activity at R132 received Catt 11/20/19. Catholic offered approximate not include details a offered Communior not to attend, or whother activities. The average of one to the day, along with other available on the leist books, crafts, puzziactivities in the last broadcast worship activity room, Bingomovies, Communicand the room to roo documentation about these activities. R132's care plan, la R132 was independent intellectual, and so on staff for meeting physical limitations with transportation wheelchair and walkeep involved in coactivities as desired providing R132 with activities, and assis functions. The care activities were work music, watching TV	attendance records showed holic Communion appeared to be ely weekly. Documentation did about whether R132 was non other weeks, and chose either R132 was offered any exactivity calendar showed an wo planned activities each er activities that were always sure cart such as games, les, etc. Examples of other two weeks included a service, community talk in the poppor in the activity room, on visits, volleyball in the gym, om leisure cart. There was no nut whether R132 was offered east revised 11/26/19, noted dent for meeting emotional, cial needs, but was dependent aphysical needs related to and needing assist from staff and ambulation using ker. The goal was for R132 to gnitive stimulation and social d. Interventions included a materials for individual sting R132 to and from activity plan noted that preferred d puzzles, reading, listening to 7, and Catholic Communion.	F 67	79		

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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
On 12/4/19, at 2:03 a friend from churc	p.m. R132 said she just had h bring her Communion over	F 67	9		
hoped her friend co that. Pharmacy Srvcs/Procedures/I	ould keep coming to visit like Pharmacist/Records	F 75	5		1/14/20
The facility must pr drugs and biologica them under an agre §483.70(g). The fa personnel to admin	ovide routine and emergency als to its residents, or obtain eement described in icility may permit unlicensed inster drugs if State law				
pharmaceutical ser that assure the acc dispensing, and ad	vices (including procedures urate acquiring, receiving, ministering of all drugs and				
receipt and disposi	tion of all controlled drugs in				
	PROVIDER OR SUPPLIER R METHODIST WEST SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa On 12/4/19, at 2:03 a friend from churc lunch. R132 was ve hoped her friend co that. Pharmacy Srvcs/Procedures/f CFR(s): 483.45(a)(§483.45 Pharmacy The facility must pr drugs and biologica them under an agre §483.70(g). The fa personnel to admin permits, but only ur a licensed nurse. §483.45(a) Procedi pharmaceutical ser that assure the acc dispensing, and ad biologicals) to mee §483.45(b) Service must employ or obt pharmacist who- §483.45(b)(1) Prov aspects of the prov the facility. §483.45(b)(2) Esta receipt and disposi sufficient detail to e	PROVIDER OR SUPPLIER R METHODIST WESTWOOD RIDGE II SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	PROVIDER OR SUPPLIER R METHODIST WESTWOOD RIDGE II SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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). 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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) Service 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

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F 755	§483.45(b)(3) Determination order and that and drugs is maintained. This REQUIREME by: Based on interview facility failed to protimely manner for reviewed for impair (ear wax) build-up. Findings include: R174's physician on "Debrox 10 gtts [drugs then flush with Ceruminosis [Exceed the cerumen (earwax)] R174's electronic of Record (eMAR) daincluded an order for (Carbamide Peroxie ears at bedtime for steps sequentially: bedtime x 3 days. Canal with tepid was indicated R174 has so far this month. When interviewed indicated, had wax ears. R174 added, and was told ear dimedical doctor (MI). When interviewed indicated indicated the record of the record	ermines that drug records are account of all controlled and periodically reconciled. NT is not met as evidenced w, and document review, the vide ear drop medications in a of 1 resident (R174) red hearing related to cerumen redered hearing related to cerumen redered hearing related to cerumen be with the vide ear daily x [times] 3 hear water Dx [Diagnosis] sive secretion or buildup of Medication Administration the description of the descripti	F 755	R174 admitted to facility on 11 Her ear medication was provid 12/2/19-12/4/19 and her ears w irrigated on 12/6/19. Physiciar to monitor ear wax build-up an accordingly. Resident has par all therapy as scheduled. Risk of re-occurrence will be m by the Director of Nursing or de initiating the following: 1)Whole house audit will be co ensure there are no medication issues with current orders. 2)Meeting held with pharmacy delivery concerns on 12/17/19. Miscommunication on ear med occurred because the pharmac the medication was part of hou be supplied by the facility. Rev stock house list that was sent t pharmacy on 4/19/19 that did r medication as house stock. Pr accurately updated their house records on 12/4/19. Pharmacy representatives identified staffi challenges on their end that ar being addressed which will ass processing orders more accura timely.	ded on were a continues of treat ticipated in minimized esignee ompleted to a delivery to review dication by thought use stock to viewed to anot list ear marmacy estock of ang e currently sist with	

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F 755	complaining ear pl nothing and been of had not been atter from cerumen in he When interviewed licensed practical in had an order for de for 3 days, then flue 11/26/19. LPN-A si transcribed in eMA R174 did not had of pharmacy did not coorder had been fay pharmacy, and had aware of the situat When interviewed confirmed R174 had drops each ear dai warm water, dated pharmacy was compharmacy was compharmacy never de facility does not had When interviewed mentioned staff ad last night around 1 days before nursin dizzy and uncomfor being removed yet When interviewed pharmacy consultationer did the facility had it in	lugs for a week now and done. F-A further stated, R174 diding therapy due to dizziness er ears. on 12/2/19, at 5:55 p.m. nurse (LPN)-A verified R174 ebrox 10 drops each ear daily sh with warm water, dated fated, the order was are. LPN-A acknowledged that debrox as ordered because the delivered the medication. The feed and called to the dimade the director of nursing ion. on 12/3/19, at 12:43 p.m. DON and an order for debrox 10 dly for 3 days, then flush with 11/26/19. DON stated, that the debrox in their house stock. on 12/3/19, at 3:57 p.m. R174 ministered the debrox ear drop 0:00 p.m. and had 2 more g flush her ears. R174 was ortable due to the wax not . on 12/4/19, at 10:37 a.m. and (PC) stated debrox is an rug and the pharmacy thought their house stock. PC miscommunication between	F 75	3)Licensed nursing staff were-educated on facility polished Medication Orders. 4)Three audits will be rand completed weekly to ensure medication delivery issues orders. 5)Audits will be ongoing used QAA monthly and a determinate that they are no long.	domly re there are no s with current ntil reviewed at mination is		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 755	10:45 a.m. pharma that the facility calle stock and this will pmiscommunication updated facility hou 11:21 a.m. PM calle showed that the facility staff on was delivered to facility staff on was delivered to facility staff on the facility staff or was delivered to facility staff or was delivered	interviewed on 12/4/19, at cy manager (PM) point out ed and updated their house prevent further. PM further stated, pharmacy use stock on their side. At ed and indicated their record cility faxed the order on /19 with a follow-up call from 12/2/19. She stated debrox cility on 12/3/19, at 3:00 a.m. on 12/5/19, at 1:32 p.m. DON tion was staff should fax new when they obtained the all provider via fax with a ded.	F 75	55		
F 880 SS=D	"Orders for new me pharmacy as a dire order as it is docum record. If facsimile the order may be tr pharmacist via pho communications wi licensed nursing stanfection Prevention CFR(s): 483.80(a)(§483.80 Infection CThe facility must estinfection preventior designed to provide comfortable environ	Il be signed and dated by aff." n & Control 1)(2)(4)(e)(f)	F 88	30		1/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245618	B. WING _		l	C / 05/2019
	PROVIDER OR SUPPLIER	WOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CO 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	program. The facility must es and control progra a minimum, the fol §483.80(a)(1) A sy identifying, reportir controlling infection diseases for all resvisitors, and other under a contractual facility assessment §483.70(e) and fol standards; §483.80(a)(2) Writt procedures for the but are not limited (i) A system of surpossible communication before the persons in the faci (ii) When and to what communicable discreported; (iii) Standard and the precautions to be finitections; (iv) When and how resident; including	stablish an infection prevention m (IPCP) that must include, at lowing elements: stem for preventing, and an and communicable sidents, staff, volunteers, individuals providing services all arrangement based upon the tronducted according to lowing accepted national stem standards, policies, and program, which must include, to: veillance designed to identify cable diseases or ney can spread to other lity; nom possible incidents of ease or infections should be ransmission-based followed to prevent spread of isolation should be used for a	F 88			
	involved, and (B) A requirement	e infectious agent or organism that the isolation should be the ssible for the resident under				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	COMF	(X3) DATE SURVEY COMPLETED	
		245618	B. WING _		12/05/2019	
	PROVIDER OR SUPPLIER	WOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CO 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	must prohibit empl disease or infected contact with reside contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A syidentified under the corrective actions (§483.80(e) Linens Personnel must hat transport linens so infection. §483.80(f) Annual The facility will con IPCP and update to	ces under which the facility oyees with a communicable I skin lesions from direct ints or their food, if direct it the disease; and ine procedures to be followed direct resident contact. stem for recording incidents in facility's IPCP and the taken by the facility.	F 88	30		
	review, the facility procedures to redu	tion, interview, and document failed to follow hand hygiene uce risk of infection for 2 of 3 and R7) observed during		R7 discharged from facility of R127 discharged from facility 12/20/19. Follow-up education comple and RN-C.	y on	
	aftercare following system, per the res 12/5/19. Nurse Practitioner	d to the facility for surgical surgery on the digestive sident's face sheet, printed (NP) visit note dated 11/25/19, abdomen to have a midline		Risk of re-occurrence will be by the Director of Nursing or initiating the following: 1)Handwashing Hand Hygie reviewed and all licensed nu be re-educated on policy. A hygiene during wound care cochecklist will be completed will be completed with the completed will be sometimes.	ne policy was rsing staff will hand competency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245618	B. WING		C 12/05/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	incision with staple from the lower part note continued that open, and to be part abdominal opening amount of pus. The to be changed twice to be changed twice During interview or described having a surgical wound. Resoon about the wo wound was deep, a comfortable packing an abdominal incision. There was a pin he with movement, an inflamed. Another the inferior aspect necrosis (dead tissed and the inferior aspect necrosis (dead tissed and infection. R127's order dated change the dressing dampened gauze provered with dry grabsorbent pad. R1 12/2/19, for 300 miles.	es, with some of the staples to of the incision removed. The to this part of the abdomen was acked with a dressing. The grontained a moderate en NP planned for the dressing are a day and as needed. In 12/02/19, at 5:32 p.m. R127 an infection of the abdominal 127 planned to see a specialist und and infection, as the and the doctor was not not the wound due to the depth. In 12/02/19, at 5:32 p.m. R127 an infection of the abdominal 127 planned to see a specialist und and infection, as the and the doctor was not not the wound due to the depth. In 12/02/19, at 5:32 p.m. R127 an infection of the abdominal 127 planned to see a specialist und and infection, as the and the doctor was not not the wound due to the depth. In 12/02/19, described pus and malodorous discharged doming from the top of the pad sized opening that oozed and the surrounding skin looked of the wound to have some fat sue). In 12/19, noted R127 was by related to the surgical 11/24/19, required nursing to not the wound, then auze, and then covered by an 27 had another order dated illigrams Clindamycin mes a day for abdominal	F 880	licensed nursing staff. 2)Three audits will be randor completed weekly to ensure hygiene during wound care. 3)Audits will be ongoing untite QAA monthly and a determinate that they are no longer	proper hand I reviewed at nation is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245618	B. WING		12	C 2 /05/2019
	PROVIDER OR SUPPLIER	VOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP COI 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	On 12/4/19, at 7:21 an appointment ton infection. R127 exp and said staff swab R127 stated staff w wound dressing late. On 12/4/19, at 10:3 (RN)-C entered R1: morning dressing c bed. RN-C prepare supplies, used hand gloves. RN-C pulled which revealed a loclosed with staples the upper part of the opening in the lowestaples had been rebeen packed with gpacking out of the wound control o	a.m. R127 confirmed having norrow morning about the lained being on antibiotics, bed the wound for a culture. ould change the abdominal	F 8	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
		245618	B. WING _		I	C / 05/2019
	PROVIDER OR SUPPLIER	WOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CO 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	in half, and gently pher finger. RN-C thusing a cotton swal RN-C changed glowhygiene. RN-C finisclean square gauze openings, and then of the entire area, be skin. R127 tucked a waistband, comme a little." RN-C remobased hand rub be a.m. In a follow-up interned mission opportunity. RN-C was asked a and confirmed mission opportunity. RN-C wash hands with so a dirty dressing, be put on a clean dresknowing what to do stated R127's abdoyellow pus that was from each open are collected a sample. On 12/4/19, laborate Coagulase positive bacteria) was grown.	coked it into the opening with en packed the upper opening, to to push the packing inside. Wes again, without any hand shed the dressing by laying e on top of the packed laying absorbent pads on top before taping it down to R127's a wash cloth into the pants inting that "it sometimes drips eved gloves, and used alcohol fore leaving the room at 10:45 wiew on 12/4/19, at 10:55 a.m. bout hand hygiene stated staff were supposed to bap and water after removing fore putting gloves back on to sing. RN-C described on, but forgetting to do it. RN-C ominal wound did have some as slowly seeping out a little ea, and commented that staff from the wound for culture. The facility for surgical surgery on the skin and the, per the resident's face	F 88	30		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245618	B. WING _			C /05/2019
	PROVIDER OR SUPPLIER	WOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		30.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPROPRICE OF CORRECTION OF CORRECT	LD BE	(X5) COMPLETION DATE
F 880	described having a wound vac (Vacuur by using a device to the wound). The care plan date antibiotic therapy resurgery. An order dated 10/2 change the KCI (brouttock wound 3x/w Wednesday and Fround vac was negcontinuous, deliver hours. "If the pump cover with Tegader maintained for 2 hrough dressing, replace wound travenously every Fascitis (dying tissue). On 12/4/19, at 1:43 entered R7's room change, while R7 latthe area with needed and donned gloves vac dressing, whice wound. The opening wound vac foam. Roopening. RN-A three the garbage. RN-A opening, without change around the foar and device the preparound the foar and the same without change around the same without	sore on his coccyx, with a massisted closure of a wound, of decrease the air pressure on delated to recent infection and 24/19, required nursing to and name) wound vac to left week. Every Monday, iday. The setting for the gative pressure of 125 mmHG ring pressure for 22 out of 24 or alarms, try to locate the leak, m. If the seal cannot be so (hours), remove vac with NS (normal saline) wet to notify MD." R7 had another 19, for Zosyn Solution that the decrease of the decrease of the decrease of the wound had to perform the dressing and on the bed. RN-A prepared the supplies, washed hands, and revealed a deep opening had been packed with the langing gloves, applied skin am and applied the adhesive and gloves, and donned new	F 88	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245618	B. WING _		l l	C / 05/2019
	PROVIDER OR SUPPLIER	WOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP COI 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	gloves without any cabinet in the room gloved hands search back to the bedside wound vac tube to a follow-up intervent. In a follow-up intervent. An and confirmed mission opportunities. RN-A changed his gloves often. An interview with Roon 12/4/19, at 2:15 perform hand hygic change gloves after the facilities Hand indicated the follow 1. b. Hands shall water whenever visbody fluicontact with such, a using the restroom c. Wash hand 2. e. Change glocare of a resident to from one body from a "dirty" site to g. Remove globefore touching none environmental another resident ar	hand hygiene. RN-A went to a a, and opened the doors with ching for supplies. RN-A came e, and completed taping the the dressing. View on 12/4/19, at 2:05 p.m. cout hand hygiene practices, sing some hand hygiene a stated he should have and washed his hands more. N-B (infection control nurse) p.m. she verified staff should an after removing gloves and removing a dressing. Hygiene Policy dated 2007 ring: I be washed with soap and sibly soiled with dirt, blood, or ds, or after direct or indirect and before eating and after im. Is after removing gloves. Is after removing gloves. Is after removing gloves. Is after removing gloves. I so are cessary, during the prevent cress-contamination site to another (when moving of a "clean" one.) I oves promptly after use, in-contaminated items and surfaces, and before going to a wash hands immediately to of microorganisms to other	F 8	30		

F5618009

PRINTED: 12/24/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		H.,	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED	
		245618	B. WING_		12/	04/2019
	PROVIDER OR SUPPLIER	WOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	ALLEGATION OF ODEPARTMENT'S ASIGNATURE AT THE PAGE OF THE CM VERIFICATION OF UPON RECEIPT OON-SITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HACCORDANCE WOF CORRECTION DEFICIENCIES (K-TAGS) TO: IF OPTING TO US OF THE PLAN OF REQUIRED. Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101 By email to: FM.HO A Life Safety Code Minnesota Department of Marshal Division Walker Methodist and in compliance of participation in Medical Page 11 of 12 of 12 of 12 of 13 of 14 of 15	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS FOMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT DIMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. I FOR THE FIRE SAFETY E AN EPOC, A PAPER COPY CORRECTION IS NOT IS SPECIOUS Division Suite 145	K 0		C	
AROBATOR	2012 edition of Nat Association (NFPA	ional Fire Protection) Standard 101, Life Safety DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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.

Electronically Signed

12/23/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED		
		245618	B. WING _		12/	04/2019
	ROVIDER OR SUPPLIER	WOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	PLEASE RETURN FM.HC.Inspections	er 19 Existing Health Care, THE PLAN to:	K 00	00		
	1. A description of v	what has been, or will be, done				
	to correct the defici 2. The actual, or pro-	ency. oposed, completion date,				
	prevent a reoccurre Walker Methodist V building with a parti constructed in 2012 Type V(111) construprotected by an aut The facility has a fir detection in the res spaces open to the	r title of the person rection and monitoring to ence of the deficiency. Vestwood Ridge II is a 1-story al basement. The facility was 2 and was determined to be of action. The building is fully comatic fire sprinkler system. The alarm system with smoke ident rooms, corridors and corridors and is monitored for rotment notification.				
	census of 33 at the	·				
	The requirement at NOT MET as evide Corridors - Constru CFR(s): NFPA 101	•	K 36	52		1/14/20
	Corridors - Constru 2012 EXISTING Corridors are separ	ction of Walls				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED		
		245618	B. WING		12/0	04/2019
	PROVIDER OR SUPPLIER R METHODIST WEST	VOOD RIDGE II		STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX T A G	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 923	rating. In fully sprint partitions are only resmoke. In nonsprint to the underside of the ceiling. Corridor underside of ceiling by Code. Fixed fire window as in accordance with compartments therefire resistance of glifthe walls have a frating the underside of the in REMARKS, described floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT by: Based on observating facility failed to Main of Walls in accordance (Code), Section 19.3.6.2.7 practice could affect Findings include: On a facility tour beautiful to the section of the	least 1/2-hour fire resistance klered smoke compartments, equired to resist the transfer of klered buildings, walls extend the floor or roof deck above walls may terminate at the is where specifically permitted ssemblies in corridor walls are Section 8.3, but in sprinklered e are no restrictions in area or ass or frames. Fire resistance rating, give the if the walls terminate at e ceiling, give brief description cribing the ceiling throughout. NT is not met as evidenced and staff interview, the intain Corridors - Construction ince with (NFPA 101 / NFPA ide / Health Care Facilities 3.6.2, 19.3.6.2.7. This deficient	K 362	The penetration in the smoke barr by the kitchen area will be repaired A whole house audit will be comple ensure the integrity of all smoke be Director of Environmental Services designee is responsible for correct monitoring to prevent re-occurrence.	I. eted to arriers. s or ion and	1/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED	
		245618	B. WING		12/	04/2019	
	PROVIDER OR SUPPLIER R METHODIST WEST			STREET ADDRESS, CITY, STATE, ZIP C 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		·	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII T A G	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 923	ventilated in accor 5.1.3.3.3. >300 but <3,000 c Storage locations within an enclosed limited- combustib gates outdoors) th gases are not stor separated from consprinklered) or enconcombustible considers available care areas with an or equal to 300 custored in an encloshandled with precay a precautionary signature and where the sign incomminimum "CAUTIC STORED WITHIN Storage is planned of which they are rempty cylinders are cylinders. When for the open are produced in the open are produced	are designed, constructed, and dance with 5.1.3.3.2 and ubic feet are outdoors in an enclosure or linterior space of non- or le construction, with door (or at can be secured. Oxidizing ed with flammables, and are mbustibles by 20 feet (5 feet if closed in a cabinet of onstruction having a minimum on rating. I to 300 cubic feet compartment, individual for immediate use in patient aggregate volume of less than bic feet are not required to be sure. Cylinders must be autions as specified in 11.6.2. gn readable from 5 feet is on of a cylinder storage room, ludes the wording as a DN: OXIDIZING GAS(ES)	K 9	Signs will be placed in oxygroom indicating full and empstorage of oxygen cylinders	oty for proper		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
		245618	B. WING		12/	04/2019	
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II			STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118				
(X4) ID PREFIX T A G	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 923	with (NFPA 101 / N) Health Care Faciliti 11.3.2, 11.3.3, 11.3. deficient practice of Findings include: On a facility tour be 12/4/2019, it was re Oxygen storage roo cylinders on the wa mixed together in the This deficient pract	FPA 99), (Life Safety Code / es Code), Section 11.3.1, .4, 11.6.5 (NFPA 99). This build affect 37 of residents. Etween the hours of (9-1pm) on evealed that we found the om isn't marked full and empty II. The K type cylinders are	K 9	Environmental Services or or responsible for correction at to prevent re-occurrence.			



 $Protecting\,,\,Maintaining\,and\,Im\,proving\,the\,\,Health\,of\,A\,I\,I\,\,Min\,n\,esotans$

Electronically delivered December 16, 2019

Administrator Walker Methodist Westwood Ridge li 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 <u>only a suggestion</u> 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		27996	B. WING		C 12/05/2019
	PROVIDER OR SUPPLIER	VOOD RIDGE II 61 THOM	DRESS, CITY, S PSON AVENI INT PAUL, M		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.			
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In a several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.			
	Department's staff v	S: 12/5/19, surveyors of this visited the above provider and tion orders are issued.			
	The following comp and found not to be H5618008C	laints were also investigated substantiated:			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/23/19

STATE FORM 6899 If continuation sheet 1 of 18 847S11

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			7 BOILBING.		؍ ا	,
		27996	B. WING		C 12/05/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
\A/A /EE	METHODIOT WEST	MOOD BIDGE II 61 THOMI	PSON AVEN	UE WEST		
WALKER	R METHODIST WEST	WEST SA	INT PAUL, N	IN 55118		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
	•					
	H5618010C					
	<u> </u>	<u> </u>				
	0	. The assigned tag number				
		eft column entitled "ID Prefix				
	•	r. This column also includes				
		are in violation of the state				
	Time period for con					
		participate in the electronic				
		e licensing orders are				
	delineated on the a					
		rected" in the box available for				
		indicate in the electronic				
		cess, under the heading				
	wiiiiicoota Departii	iont of Ficultii.				
		ARD THE HEADING OF THE				
	The Minnesota Dep documenting the Si Orders using federa been assigned to M for Nursing Homes appears in the far le Tag." The state stalisted in the "Summ column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Correceipt of State lice the Minnesota Dep Informational Bulleth http://www.health.sobul.htm The State delineated on the and Department of Hear you electronically, is necessary for State licensure procompletion date, the corrected prior to empletion date, the Corrected DISREGA FOURTH COLUMN	eft column entitled "ID Prefix atute/rule out of compliance is a lary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state atement, "This Rule is not met ollowing the surveyors findings Method of Correction and rection. To participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are attached Minnesota alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading e date your orders will be a lectronically submitting to the ment of Health. ARD THE HEADING OF THE				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		27996	B. WING		12/0	; 5/2019	
	NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa		2 000				
	THIS WILL APPEA IS NO REQUIREM CORRECTION FO	ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES					
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			1/14/20	
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.					
	by: Based on observati review, the facility for procedures to reduce	on, interview, and document ailed to follow hand hygiene ce risk of infection for 2 of 3 observed during dressing		Corrected.			
	Findings include:						
	aftercare following	to the facility for surgical surgery on the digestive ident's face sheet, printed					
	described R127's a incision with staples from the lower part note continued that open, and to be parabdominal opening amount of pus. The	NP) visit note dated 11/25/19, bdomen to have a midline s, with some of the staples of the incision removed. The this part of the abdomen was cked with a dressing. The contained a moderate NP planned for the dressing e a day and as needed.					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION (X3) DATE SUF COMPLET		
			A. BOILDING.			,
		27996	B. WING		12/05/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST WEST	WOOD RIDGE II	IPSON AVEN AINT PAUL, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	age 3	21375			
	described having a surgical wound. R1 soon about the wou wound was deep, a comfortable packin. R127's progress not a large amount of pon the dressing and abdominal incision, There was a pin he with movement, an inflamed. Another r	n 12/02/19, at 5:32 p.m. R127 n infection of the abdominal 27 planned to see a specialist and and infection, as the and the doctor was not g the wound due to the depth. Otes dated 11/30/19, described bus and malodorous discharged coming from the top of the which was intact with staples and sized opening that oozed d the surrounding skin looked note dated 12/2/19, described of the wound to have some fature).	-			
	R127's care plan dated 12/2/19, noted R127 was on antibiotic therapy related to the surgical wound infection.					
	change the dressin dampened gauze p covered with dry ga absorbent pad. R12 12/2/19, for 300 mil	I 11/24/19, required nursing to g twice daily, with saline backed into the wound, then auze, and then covered by an 27 had another order dated lligrams Clindamycin nes a day for abdominal r ten days.				
	an appointment ton infection. R127 exp and said staff swab R127 stated staff w wound dressing late	-				
	On 12/4/19, at 10:3	32 a.m. registered nurse				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		1	7t. BOILDING.		_ ا	
		27996	B. WING		12/0	<i>,</i> 5/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VAVA I IZEE	METHODICT WEST	WOOD BIDGE II 61 THOME	PSON AVEN	UE WEST		
WALKER	R METHODIST WEST	WEST SA	INT PAUL, N	IN 55118		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa		21375			
	(RN)-C entered R1 morning dressing of bed. RN-C prepare supplies, used han gloves. RN-C pulle which revealed a loc closed with staples the upper part of the opening in the lowestaples had been rebeen packed with opacking out of the cout of the wound on RN-C threw the gard gloves, and donner hygiene. RN-C were opened the doors of supplies. RN-C and wet gauze to copen areas. As RN R127's abdomen with drop of liquid appearance of the drop of opening. R127 mendabbed the drop of opening.	27's room to perform the change, while R127 laid on the ed the area with needed d sanitizer, and donned d off the old absorbent pad, ong surgical incision, mostly and the incision, and a second er part of the incision, where emoved. The openings had gauze. RN-C pulled the openings. The gauze coming ontained a yellow substance. The garbage, removed and new gloves without any hand to a cabinet in the room, and with gloved hands searching came back to the bedside, elean the skin surrounding the lack garbage on the surrounding the lack growth on the moistened gauze, a pared from the lower opening. The pus coming out," as RN-C for liquid coming from the moistened feeling tender on the sion. RN-C threw the gauze in moistened clean gauze. RN-C wer opening, but the gauze fell of it in the garbage. RN-C wer opening, but the opening with the packed it into the opening with the packed it into the opening with the packed the upper opening, but the gauze folded the square ooked it into the opening with the packed the dressing by laying the on top of the packed				
	openings, and ther of the entire area, the	n laying absorbent pads on top before taping it down to R127's				
	skin. R127 tucked	a wash cloth into the pants				1

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
					С		
		27996	B. WING		1	5/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
WALKER	R METHODIST WEST	NOOD RIDGE II	PSON AVEN				
(VA) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	INT PAUL, M		ON	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 5	21375				
	a little." RN-C remo	nting that "it sometimes drips oved gloves, and used alcohol fore leaving the room at 10:45					
	RN-C was asked a and confirmed miss opportunity. RN-C wash hands with so a dirty dressing, be put on a clean dresknowing what to do stated R127's abdoyellow pus that was from each open are	view on 12/4/19, at 10:55 a.m. bout hand hygiene practices, sing a hand hygiene stated staff were supposed to pap and water after removing fore putting gloves back on to sing. RN-C described by but forgetting to do it. RN-C primal wound did have some as slowly seeping out a little ea, and commented that staff from the wound for culture.					
	On 12/4/19, laboratory results showed Coagulase positive Staphylococcus (a type of bacteria) was growing in the wounds.						
	aftercare following	the facility for surgical surgery on the skin and se, per the resident's face (19.					
	described having a wound vac (Vacuur	1 12/02/19, at 7:34 p.m. R7 sore on his coccyx, with a m assisted closure of a wound, o decrease the air pressure on					
		d 11/13/19, noted R7 was on elated to recent infection and					
		24/19, required nursing to and name) wound vac to left					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27996	B. WING		C 12/05/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST WEST	NOOD RIDGE II	PSON AVEN INT PAUL, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Wednesday and Fr wound vac was neg continuous, delived hours. "If the pump cover with Tegader maintained for 2 hr dressing, replace women was dressing and order dated 11/19/1 (antibiotic) Reconstintravenously every Fascitis (dying tissue) On 12/4/19, at 1:43 entered R7's room change, while R7 lathe area with needed and donned gloves vac dressing, which wound. The opening wound vac foam. Roopening. RN-A threathe garbage. RN-A opening, without charper around the foasheet over, remove gloves without any cabinet in the room gloved hands search back to the bedside wound vac tube to the follow-up intervals and confirmed missiopportunities. RN-A and search and confirmed missiopportunities. RN-A	week. Every Monday, iday. The setting for the gative pressure of 125 mmHG ring pressure for 22 out of 24 or alarms, try to locate the leak, m. If the seal cannot be is (hours), remove vac with NS (normal saline) wet to notify MD." R7 had another 19, for Zosyn Solution tituted 3.375 GM (grams) or 6 hours for Nercotizing are) until 12/3/19 11:59 p.m. Is a.m. registered nurse (RN)-A to perform the dressing and on the bed. RN-A prepared and supplies, washed hands, and RN-A pulled off the wound the revealed a deep opening had been packed with the foam and dressing in cut new foam to fit the analysing gloves, applied skin am and applied the adhesive and gloves, and donned new hand hygiene. RN-A went to a and opened the doors with ching for supplies. RN-A came and completed taping the	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27996	B. WING		C 12/05/2019	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/0	5/2019
WALKER	R METHODIST WEST	NOOD RIDGE II	PSON AVENI INT PAUL, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From page 7		21375			
	on 12/4/19, at 2:15 perform hand hygic change gloves afte The facilities Hand indicated the follow 1. b. Hands shal water whenever vis body flui contact with such, a using the restroo c. Wash hand 2. e. Change glo care of a resident to from one body from a "dirty" site to g. Remove gl before touching no environmental another resident ar	I be washed with soap and sibly soiled with dirt, blood, or ids, or after direct or indirect and before eating and after om. Is after removing gloves. It is afte				
	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.					

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	E COPPECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		27996	B. WING		C 12/05/2019	
NAME OF I	PROVIDER OR SUPPLIER		DESS CITY S	STATE, ZIP CODE	12/0	0/2010
		61 THOMI	PSON AVEN			
WALKER	R METHODIST WESTV	WEST SA	INT PAUL, N	IN 55118		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From pa	ge 8	21375			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21435	MN Rule 4658.0900 Recreation Program	O Subp. 1 Activity and n; General	21435			1/14/20
	home must provide recreation program based on each indistrengths, and need meet the physical, is well-being of each is comprehensive rescomprehensive plat 4658.0400 and 465 provided opportunit	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and .				
	by: Based on interview review, the facility for programming to fit to residents (R128 an activities, and one of	ent is not met as evidenced , observation, and record ailed to provide activity the interests of 2 of 2 d R132) investigated for other resident (R125) to have missed an activity of		Corrected.		
	Findings include:					
	12/2/19, at 2:49 p.n here. R128 said he wanted to know wh facility. There was r	d sitting in his room on n. R128 stated he was bored had books from home, but he at was going on around the no calendar of activities ted anywhere in sight in his				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		27996	B. WING		I	C 05/2019
	PROVIDER OR SUPPLIER	NOOD RIDGE II 61 THO	ADDRESS, CITY, S DMPSON AVEN SAINT PAUL, N	UE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21435	R128 had admitted care plan initiated of include any informal preferences. An Activity Interview Preferences dated important for R128 and magazines to rnews, to get outside and to do things with backside of the Initial 11/26/19, listed son questions. R128 not and see movies with able to watch televinglay bingo. R128 likewatching sports or During interview on assistant director of explained that a well-printed and distribution enrichment assistant the programming. A activities were indivisione group activities on 12/4/19, at 8:34 for yesterday were from the main nursity the activity room. Yindividual activities	d not remember anyone vity calendar. recently on 11/24/19, and the on the date of admit did not yeation about activity In for Daily and Activity 11/26/19, noted it was very to have books, newspapers read, to keep up with the effor fresh air in good weather the groups of people. The ital Leisure Assessment date ne hand written answers to oted liking to eat with others, the others. R128 hoped to be sion, read, talk to visitors, and the news. 12/3/19, at 3:29 p.m. the fife enrichment (ADLE) rekly calendar of activities we ted to each room by life ints, to let residents know of ADLE said most of the vidual activities, but there we vidual activities, but there we	eet eer, d as re sssssssssssssssssssssssssssssssss			

6899

Minneso	ta Department of He	eaith earth	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPI	LETED
)
		27996	B. WING		1	5/2019
NAME OF F	PROVIDER OR SUPPLIER	CTDEET AL	DDDESS CITY (STATE ZID CODE		
NAIVIE OF F	-ROVIDER OR SUPPLIER			STATE, ZIP CODE		
WALKER	METHODIST WEST	WOOD RIDGE II	IPSON AVEN AINT PAUL, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21435	Continued From pa		21435			
	On 12/4/19, at 8:41 dining room with a and F-B were aske a weekly activity so each week. R128 h she never saw it, a daily. R128 asked or programming was purprised to hear it activity room daily. the activity schedul building, and commice to know, or to room and ask if he that day. F-B explathe facility, they felt what went on or whings worked arou were activities one activities going on, was supposed to k posted without beir "[R128] has rehab, of the day, you just and watch [television biggest complaint; do. A nursing progress p.m. noted F-B "wais nothing to do her bored.' F-B would rexplain it is a thera after therapies."	If a.m. R128 was seated in the family member (F)-B. R128 and about whether they received chedule brought to the room and not seen it, and F-B said and sometimes visited twice whether the activity posted anywhere, and was awas posted outside the F-B was also unaware that le was posted anywhere in the nented that it would have been have staff come by R128's was interested in the activity ined when R128 first came to the dropped in, and had no clue no to talk to to find out how and the facility, or that there could do. F-B never saw any and did not know how anyone now there was a schedule and then the other 23 hours a sit in your room on your bed on]." F-B stated that was her there was nothing for R128 to a note dated 11/29/19, at 3:05 as very rude and stated 'there are, all [R128] does is sit and be not listen when [staff] tried to apy department and most rest				
	one of the life enric	m. ADLE explained she and chment assistants performed ats, and then indicated				

6899

Millinesc	ta Department of He	zaitii					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			D WING		C		
		27996	B. WING		12/0	5/2019	
NAME OF I	PROVIDER OR SUPPLIER	STDEET VI	NDESS CITY S	STATE, ZIP CODE			
NAIVIL OI I	-NOVIDEN ON SUFFEIEN						
WAI KER	METHODIST WEST	WOOD RIDGE II	IPSON AVEN				
		WEST SA	AINT PAUL, N	IN 55118			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	PRIATE	DATE	
				DEFICIENCY)			
24425	On attract of France or	44	04405				
21435	Continued From pa	age 11	21435				
	that was due. In a follow up interview at 11:37						
	a.m. with ADLE and						
		DLE stated they were working					
	,	track which residents attended					
	which activities. Th	e current activity tracking					
	system for Novemb	per and December was					
	•	8 was not documented to					
		n any activities during his stay					
		ined that the leisure cart was					
	•	om to room once a week, but					
	there was no docur	mentation that R128 took				l	
	anything from the le	eisure cart. DLE said the				l	
	leisure cart going re	oom to room weekly was one				l	
		nent staff could check in with				l	
		if residents or family had				l	
						l	
		tivities, the life enrichment staff				l	
		out it to find an activity of				l	
	interest for them. D	LE explained that family might				l	
	talk to nursing staff	about their concerns, and					
		n was for nursing staff to pass					
		to life enrichment staff.					
		DLE, were aware of the					
	•	•					
	0.0	ote dated 11/29/19, that					
		es-related concern R128's					
		nursing staff. DLE and ADLE					
	stated they would h	nave expected the staff to					
	bring this issue to t	heir attention, and then they					
		th him to try and fix the				l	
	problem.	arram to aly arram are					
	problem.						
	D40E adm:!!!ad ! - !!	as facility for the series and see-					
		ne facility for therapy, and was					
		I to miss an activity of interest					
	when she was unav	ware of the activity, and was					
	not asked if she wa	anted to participate.					
	_						
	On 12/4/19 at anni	roximately 1:40 p.m. life					
		nt (LEA)-A stood in the					
		t to a popcorn machine. The				ı	
	smell of poncorn fil	led the hallways I FA-A joked					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27996	B. WING		C 12/05/2019	
	PROVIDER OR SUPPLIER	VOOD RIDGE II 61 THOMI	DRESS, CITY, S PSON AVENI INT PAUL, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	residents, and state to the activity room would bring a bag of 1:49 p.m. R125 was a wheelchair out into commented on how asked if she receive stated, "No, I didn't popcorn, but then I smelled it." R125 as looked into the activity down the popcorn r like it is all gone." L gone, and stated sh R125 was taking a finished cleaning the weekly activity scheme.	ade LEA-A popular with the ed if residents could not come for popcorn, then LEA-A of popcorn to their room. At so observed to propel herself in to the main hallway. R125 or good the air smelled. When ed any popcorn yet, R125 even know there was came out of my room and sked, "Where is it?" R125 vity room to see LEA-A wiping machine and stated, "Looks EA-A confirmed it was all ne went by R125's room, but nebulizer at the time. LEA-A e popcorn machine. The edule showed the popcorn sposed to be over until 2:00	21435			
	observed sitting in linterview at 6:35 p. much to do except stated, "I'm bored to doing word searche book on her over-thmentioned there was boring."	7/19 for therapy, and was her room on 12/2/19. During m. R132 said there was not turn the television on. R132 tears." R132 described es, and had a word search he-bed table, but again as not much to do and, "It gets				
	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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			A. BUILDING:		C	
		27996	B. WING		12/05/2019	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WALKER	R METHODIST WEST	NOOD RIDGE II	PSON AVENI INT PAUL, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	enjoyed knitting over enjoyed playing bore eating with others, movies with others. Review of activity at R132 received Cattl 11/20/19. Catholic offered approximate not include details a offered Communior not to attend, or who other activities. The average of one to traday, along with other available on the leist books, crafts, puzzi activities in the last broadcast worship activity room, Bingomovies, Communicand the room to road documentation about these activities. R132's care plan, la R132 was independent intellectual, and soon staff for meeting physical limitations with transportation wheelchair and walkeep involved in conactivities as desired providing R132 with activities, and assis functions. The care activities were worked.	er the past month, and ard games with other people, and watching sports and	21435			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		27996	B. WING		12/0) 5/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST WESTV	VOOD RIDGE II	PSON AVEN INT PAUL, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 14	21435			
	Prior to R132's adm board games, and	nission, R132 enjoyed knitting, 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 (21) days.	R CORRECTION: Twenty-one				
21550	MN Rule 4658.1329 Medications; Pharm	5 Subp. 1 Adminiatration of nacy Serv.	21550			1/14/20
		ncy services. A nursing home e provision of pharmacy				
	by: Based on interview facility failed to prov timely manner for 1	ent is not met as evidenced , and document review, the vide ear drop medications in a of 1 resident (R174) ed hearing related to cerumen		Corrected.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	27996	B. WING		12/0)5/2019
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTW	VOOD RIDGE II 61 THOM	DRESS, CITY, S' PSON AVENU NINT PAUL, M	JE WEST		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
"Debrox 10 gtts [dro days then flush with Ceruminosis [Exces cerumen (earwax)]." R174's electronic M Record (eMAR) data included an order for (Carbamide Peroxic ears at bedtime for steps sequentially: bedtime x 3 days. Go canal with tepid wat indicated R174 had so far this month. When interviewed or indicated, had wax (ears. R174 added, so and was told ear dro medical doctor (MD). When interviewed or member (F-A) state complaining ear plus nothing and been do had not been attend from cerumen in her when interviewed or licensed practical number for definition of the control of the control of the cerumen in her when interviewed or licensed practical number for definition of the cerumen in her when interviewed or licensed practical number for definition of the cerumen in her when interviewed or licensed practical number for definition of the cerumen in her when interviewed or licensed practical number for definition of the cerumen in her when interviewed or licensed practical number for definition of the cerumen in her when interviewed or licensed practical number for definition of the cerum o	der dated 11/26/19, read, ops] each ear daily x [times] 3 a warm water Dx [Diagnosis] sive secretion or buildup of " dedication Administration ed 12/1/19 to 12/4/19, or Debrox Solution de), instill 10 drops in both cerumen for 3 Days Perform 10 drops to affected ear at Sently irrigate affected ear(s) for on the 3rd day. The eMAR received the drops 2 times on 12/2/19, at 1:36 p.m. R174 (cerumen) build-up in her she reported to nursing staff op order was obtained from on 11/26/19. on 12/2/19, at 5:27 p.m. family d, R174 had been gs for a week now and one. F-A further stated, R174 ding therapy due to dizziness r ears. on 12/2/19, at 5:55 p.m. curse (LPN)-A verified R174 brox 10 drops each ear daily th with warm water, dated	21550			

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			A. BUILDING:		С	
		27996	B. WING		12/05/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST WEST	NOOD RIDGE II	PSON AVENI INT PAUL, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21550	Continued From pa	ige 16	21550			
	R174 did not had d pharmacy did not d order had been fax pharmacy, and had aware of the situati When interviewed of confirmed R174 had drops each ear dail warm water, dated pharmacy was confirmed	on 12/3/19, at 12:43 p.m. DON d an order for debrox 10 ly for 3 days, then flush with 11/26/19. DON stated, tacted 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		27996		B. WING		l l	C 05/2019
	PROVIDER OR SUPPLIER	WOOD RIDGE II	61 THOM	DRESS, CITY, S PSON AVEN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21550	When interviewed of stated, the expectation orders to pharmacy orders from medication follow-up call if need. The facility policy at MEDICATION ORE "Orders for new method pharmacy as a director order as it is documered. If facsimiles the order may be to pharmacist via phocommunications will licensed nursing states and the states of the control of the states of the	cility on 12/3/19, at 3 on 12/5/19, at 1:32 point on was staff should when they obtained all provider via fax with ded. Independent of the procedure titled of the procedure titled of the procedure titled of the procedure of the prescription of the prescription of the prescription of the prescription of the procedure titled on the facility's transmission in not a consmitted directly to the procedure. All facsimile of the procedure of the prescription of the pres	m. DON fax new the n a read, to the iption a medical vailable, a red by	21550			

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