Electronically Delivered

December 1, 2023

Licensee
Walker Methodist Place
3701 Bryant Avenue South
Minneapolis, MN 55409

RE: Project Number(s) SL20447015

Dear Licensee:

On October 31, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 1, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 1-866-890-9290

PMB

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September 28, 2023

Licensee
Walker Methodist Place
3701 Bryant Avenue South
Minneapolis, MN 55409

RE: Project Number(s) SL20447015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-247-0268 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20447	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLACE	3701 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20447015 On August 29, 2023, through September 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 101 active residents, 36 of whom received services under the Assisted Living license. The immediacy of order 2310 was removed on September 1, 2023, based on supervisor review. The scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 29, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff appropriately gloved and performed adequate hand hygiene for one of two staff (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired May 15, 2023, to provide direct cares for the licensee's residents. On August 30, 2023, at 8:20 a.m., ULP-B was observed to use the hand sanitizer on the medication cart and then proceed to punch R5's morning medication into a medication cup. ULP-B entered R5's room, placed R5's medication cup onto the end table next to R5 and assisted R5's	0 510		

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0 510	Continued From page 3 with placing her hearing aids. R5 then ambulated independently to the bathroom and onto the toilet. While R5 was sitting on the toilet, ULP-B proceeded to assist with morning cares. Without washing hands, ULP-B applied (donned) gloves, removed R5's used incontinent brief and placed the brief into a trash bin. ULP-B placed a new brief and assisted R5 with putting on pants. ULP-B then assisted R5 with replacing her shirt. R5 independently pulled up her brief and her pants. ULP-B removed (doffed) her gloves and placed them into the trash bin. ULP-B then, without washing or sanitizing hands, donned new gloves. ULP-B proceeded to assist R5 with combing the back of her hair. Wearing the same gloves, ULP-B exited the bathroom and made R5's bed. ULP-B doffed gloves and exited R5's room to retrieve R5's inhaler that ULP-B had left on the medication cart. ULP-B returned to R5's room and handed R5 her medication cup from the end table. R5 was observed to take her morning medications. Once R5 had finished taking the medications that were in the medication cup, ULP-B removed the inhaler from a small plastic bag, shook the inhaler and handed it to R5. ULP-B placed the inhaler back into the bag and exited R5's room. On August 30, 2023, at 8:45 a.m., ULP-B stated she had been tested on hand washing and wearing gloves. ULP-B further stated hands should be washed after assisting residents to the bathroom, which she "tries to do" but "most" residents only have towels in their apartments and stated, "I don't like to dry my hands on residents' towels." On August 30, 2023, at 12:45 p.m., director of nursing (DON)-A stated the ULPs are to wash hands and change gloves throughout cares.	0 510		

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0 510	Continued From page 4 The CDC guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated November 29, 2022, indicated healthcare personnel (HCP) should perform hand hygiene immediately before touching a patient, after touching a patient or the patient's immediate environment and immediately after glove removal. The licensee's Hand washing policy revised July 23, 2021, indicated hand hygiene products would be readily accessible and convenient for staff. The policy further indicated hand washing would be performed by all employees before moving from a contaminated body site to a clean body site during resident care, after removing gloves, and before and after direct contact with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 5 Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 29, 2023, from approximately 10:30 a.m. to 1:30 p.m., survey staff toured the facility with the environmental services director (ESD)-E and the regional director of environmental services (RESD)-G. It was observed that apartment #804 had a missing ceiling tile in the primary bedroom closet, which could negatively impact the function of the adjacent sprinkler head. The apartment also had some water damage on the ceiling in the guest bathroom near the fan, and in the primary bedroom over the sleeping area. The ceiling was discolored and the texture had fallen off in some areas. The wallpaper was peeling off the walls along the ceiling and at material joints in the public bathrooms on floors seven, six, five, and four. There were six large portions of the rated drywall	0 800		

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0 800	Continued From page 6 milling in the building storage room on the sixth floor near apartment 614. There were three missing rated drywall sections in the utility closet on the fourth floor near apartment 414. There were two missing rated drywall sections in the janitor closet on the second floor by apartment 214. Rated walls in storage areas must be complete and maintained to meet the fire safety rating required by code. ESD-E and RESD-G visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 7 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on	0 810		

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0 810	Continued From page 8 August 29, 2023, at approximately 2:00 p.m. with the environmental services director (ESD)-E and the regional director of environmental services (RESD)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, ESD-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. Training records of "MN Emergency Preparedness New Hire Training" were provided for review. Reocrds indicated that most of the staff were marked as "compliant", but employee hire dates were not indicated on the documents. Survey staff could not verify which staff were hired before August 1, 2021, when training requirements went into effect for state licensure. During interview, ESD-E stated the licensee provided training to staff upon hire and annually thereafter but did not have any further documentation on employee training on the fire safety and evacuation plan that indicated all staff were receiving the correct amount of training.	0 810		

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0 810	Continued From page 9 Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided records indicated that fire drills were completed on 6/29/23, 5/30/23, 5/15/22, 4/15/22, 2/22/22, 12/21/21, 12/25/21, 9/9/21, and 2/18/21. During interview, LALD-A verified that there were no additional documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of three residents (R5).	01760		

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01760	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5's diagnoses included congestive heart failure and asthma. R5's service plan dated July 18, 2023, indicated R5 received services to include medication management. R5's medication administration record (MAR) dated August 2023, indicated R5 received Fluticasone HFA 110 micrograms corticosteroid inhalation aerosol (used for asthma) at 8:00 a.m. On August 30, 2023, at 8:20 a.m., unlicensed personnel (ULP)-B was observed to take R5's inhaler out of a small plastic bag, shake the inhaler, and remove the cap. ULP-B then handed the inhaler to R5 who inhaled one puff by mouth. ULP-B replaced the cap on the inhaler and returned the inhaler to the bag. ULP-B then exited the room without prompting R5 to rinse her mouth with water. On August 30, 2023, at 11:30 a.m., ULP-B stated she was taught on the use of oral inhalers. ULP-B further stated she knew residents should rinse their mouth after using "the round purple one." On August 30, 2023, at 12:45 p.m., director of nursing (DON)-A stated all unlicensed personnel	01760		

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WALKER METHODIST PLACE	3701 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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01760	Continued From page 11 are trained during orientation on how to administer inhalers. The Food and Drug Administration's 2019 prescribing information for fluticasone oral inhalation use indicated patients should be advised to rinse their mouth with water without swallowing after inhalation to prevent fungal infection. The licensee's Metered Dose Inhaler procedure form dated 2012, indicated the ULP should have residents rinse their mouth following inhaler use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure medications were securely locked and ensure only authorized personnel had access to medications for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01880		

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01880	Continued From page 12 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). On August 30, 2023, at 8:20 a.m., unlicensed personnel (ULP)-B was observed to take a small plastic bag containing R5's inhaler out of a drawer of a medication cart located in the hallway and placed the bag on top of the cart. ULP-B proceed to punch the rest of R5's medications out of their bubble pack and place them into a medication cup. ULP-B gathered the medication cup and entered R5's apartment. ULP-B place R5's medication cup onto the end table next to R5 and assisted R5's with her morning cares. Once cares were completed, ULP-B acknowledged she had left R5's inhaler unattended on the medication cart located in the hallway and exited the apartment to retrieve the inhaler. ULP-B brought the inhaler back to R5's room and assisted R5 with her morning medications. On August 30, 2023, at 8:45 a.m., ULP-B stated she "sometimes" forgets the inhaler on the cart. ULP-B further stated she was "pretty much not supposed to." On August 30, 2023, at 12:45 p.m., director of nursing (DON)-A stated the ULPs were instructed to never leave medications unattended on the medication cart. The licensee's Medication Management Services policy revised August 9, 2023, indicated medications outside of a resident's living space would be securely locked and would permit only authorized staff members to have access. No further information was provided.	01880		

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01880	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber orders for oxygen therapy were correctly transcribed for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted to licensee on November 11, 2019, with diagnoses of generalized anxiety disorder, urge incontinence, major depressive	01960		

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01960	Continued From page 14 disorder, and unspecified visual disturbance. R4's provider's order dated July 5, 2023, indicated R4 was to receive oxygen at four (4) liters per minute via nasal canula. R4's August 2023 medication administration record (MAR) indicated R4 was to receive oxygen via nasal cannula at two to four liters per minute continuous. On August 30, 2023, at 8:30 a.m., R4 was observed to be lying in bed with a nasal cannula in her nose and the oxygen concentrator set at 4 liters. ULP-B was observed to check R4's oxygen saturation level using an oximeter and recorded level to be 96%. On August 31, 2023, at 3:25 p.m., director of clinical services (DCS)-F acknowledged there was a difference between the prescriber order and what was indicated on the medication administration record. The licensee's Treatment and Therapy Management Services policy revised July 27, 2021, indicated the nurse would verify all treatments and therapy were administered as prescribed. The policy further indicated the treatment or therapy management record would be updated with any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders	01970		

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01970	Continued From page 15 There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed ensure up-to-date written or electronically treatment order was maintained for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on June 2, 2021, with diagnoses of obstructive sleep apnea (breathing disorder during sleep), repeated falls, dementia without behavioral disturbance, osteoarthritis, and peripheral vascular disease. R3's Service Plan Agreement signed May 4, 2023, indicated R3 received services to include bathing, dressing, toileting, continuous positive airway pressure (CPAP) assistance, compression sock assistance, bed making, laundry, and	01970		

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01970	Continued From page 16 medication management. R3's Level of Care Assessment dated July 24, 2023, indicated R3 required assistance with CPAP application and cleaning mask one time a day. On August 30, 2023, at 9:05 a.m., surveyor was in R3's apartment interviewing R3 and observed a CPAP machine on the dresser next to R3's bed. R3 stated he received help with putting it on at bedtime. R3's Progress Note (provided by medical provider) signed by certified nurse practitioner on June 21, 2023, indicated R3 "has a CPAP. Denies acute complaints at this time." The Progress Note lacked the frequency, duration, and other information needed to administer the treatment or therapy. R3's medical record lacked a current signed treatment order for CPAP. During interview September 1, 2023, at 4:25 p.m., DON-A stated the Progress Note dated June 21, 2023, contained a current order for R3's CPAP. Surveyor explained the Progress Note did not contain the above required information and DON-A stated it did not contain the required information. The licensee's Treatment and Therapy Management Services policy dated August 2005, last revised on July 27, 2021, indicated the licensee would obtain an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The policy also indicated the order must include: -name of resident;	01970		

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01970	Continued From page 17 -description of treatment or therapy; -frequency and duration and other information needed to administer the treatment or therapy; and -must be renewed at least every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R3, R4) who utilized consumer bed rails. Further, the licensee failed to ensure that oxygen cylinders were properly stored for one of three residents (R4). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	02310		

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02310	Continued From page 18 portion or all of the residents). The findings include: R3 R3 was admitted to the licensee on June 2, 2021, with diagnoses of repeated falls, dementia without behavioral disturbance, osteoarthritis, and peripheral vascular disease. R3's Service Plan Agreement signed May 4, 2023, indicated R3 received services to include bathing, dressing, toileting, escorts to meals, bed making, laundry, and medication management. R3's Uniform Nursing Assessment dated July 24, 2023, indicated under "Section 2. Functional Capabilities," that R3 used a Halo (round grab bar) for bed mobility. R3's Physical Device Assessment signed by a registered nurse (RN) on April 19, 2023, indicated R3 had a Halo grab bar on both sides of the bed to increase independence with bed mobility and transfers in and out of bed. The assessment also indicated the Halo grab bars were installed per manufacturer's guidelines. R3's Progress Notes dated August 24, 2023, at 6:36 a.m., indicated staff called an on-call RN to report that R3 rolled out of his bed, hitting his head on the dresser. R3 was found lying on the floor on his stomach. R3 was back into bed when RN triage was contacted. On August 30, 2023, at 9:10 a.m., the surveyor observed R3's queen size bed with Halo grab bars on each side of the head of the bed. Both Halo grab bars were loose which moved approximately 20 degrees forward and	02310		

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02310	Continued From page 19 backwards. R3's medical record lacked a current physical device assessment and evidence the licensee referenced to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. In addition, R3's bilateral Halo grab bars were not securely attached to R3's bed. R4 R4 was admitted to licensee on November 11, 2019, with diagnoses of generalized anxiety disorder, urge incontinence, major depressive disorder, and unspecified visual disturbance. R4's Service Plan Agreement signed August 7, 2023, indicated R4 received services to include medication administration, oxygen therapy, bed making, and repositioning. R4's Physical Device Assessment dated March 8, 2023, indicated R4 had a Halo grab bar on each side of the bed. The assessment indicated the Halo grab bars were used to help increase independence with bed mobility and transfers in and out of bed. On August 30, 2023, at 9:30 a.m., R4 was observed to be lying in bed, under covers, with an oxygen nasal cannula placed in her nose. Halo bed rails were observed to be secured on the right and left side of the bed. R4's medical record lacked a current physical device assessment and evidence the licensee referenced the CSPC for the most up-to-date information related to portable bed side rail recall information.	02310		

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02310	Continued From page 20 The licensee's Physical Device Log dated August 7, 2023, contained the following information to document: -residents' who had a bedrail; -reason for device; -consent/risks vs benefit reviewed with resident/family; -measurement completed per FDA or CPSC and per manufacturer's guidelines; - recall verified at initial, quarterly and change in condition; and -nurse logging with title. The Physical Device Log lacked documentation R3 and R4's devices were checked for recalls. During interview and observation on August 30, 2023, at 1:40 p.m., director of nursing (DON)-A stated they perform physical device assessments initially when installed, 14 days after installation and every 90 days thereafter. DON-A stated they assess safety for each resident using a siderail. Surveyor asked DON-A to inspect the Halos on R3's bed and DON-A moved both Halos and indicated they were "shaky." DON-A stated resident services manager (RSM)-I is responsible for physically checking the installation of the siderails. DON-A stated they had not been checking for recalls. On August 30, 2023, at 3:00 p.m., DON-A and RSM-I provided the physical device policy and physical device log. RSM-I stated they went into R3's room about a month ago and felt that both Halos were snug but did not document their observation. RSM-I stated they did a bedrail audit on August 7, 2023, but did not check for recalls at that time. DON-A stated environmental services director (ESD)-E was responsible for installing the bedrails per manufacturer's guidelines, measuring, and checking for recalls.	02310		

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02310	Continued From page 21 On August 31, 2023, at 9:20 a.m., ESD-E stated he was responsible for installing the siderail within the parameters of the manufacturer's guidelines but did not routinely check to make sure siderails continued to be installed correctly. Once the siderail is installed, ESD-E stated he will notify RSM-I of completion and RSM-I would check measurements of the four zones. ESD-E stated he was not trained to check for recalls. On August 31, 2023, at 11:00 a.m., regional director of clinical services (RDCS)-F stated the licensee updated the physical device policy in July of 2023. The old policy indicated to check for recalls annually. The new policy indicated to check for recalls every 90 days. RDCS-I stated the new policy did not state who was responsible for checking recalls, but she expected the RN to check when they do their assessments. RDCS-F stated she thought when a Halo was attached to a hospital bed it was classified as a hospital siderail. Surveyor provided education on the difference between a hospital siderail and consumer side rail and referenced Minnesota Department of Health (MDH) website containing detailed information. On August 31, 2023, at 11:40 a.m., unlicensed personnel (ULP)-B stated she thought she had training on bed rails during orientation and stated she had been trained to encourage residents to hold on to the bed rails "if they are needing to use it to get up." ULP-B further stated she would notify the nurse if the bed rail was "broke" or "unsturdy [sic]." On August 31, 2023, at 11:50 a.m., ULP-H stated she had been trained to notify the nurse if a new bed rail was noticed, in order "to make sure	02310		

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02310	Continued From page 22 family didn't bring it in." ULP-H further stated, "I wouldn't know what else to be concerned about." The Food and Drug Administration's (FDA) A Guide to Bed Safety dated October 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;	02310		

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02310	Continued From page 23 - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." The licensee's Physical Devices Policy last revised on July 19, 2023, indicated an assessment would be completed to validate the resident's ability to utilize the device safely. A physical device assessment would be completed by an RN upon move in or start of services, upon initial recommendation, with every 90-day assessment and when the resident has a significant change of condition. The policy indicated the devices would be checked for recalls initially and with every 90-day or change of condition assessment. The policy indicated the licensee would complete the Physical Device Checklist and place in chart. The policy indicated all staff members would be instructed to notify the nurse and/or environmental services, if they notice a physical device that appears, damaged, loosened, or needs adjustments immediately. No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy of order 2310 was removed on September 1, 2023, based on supervisor review. The scope and level remain unchanged.	02310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 24 OXYGEN STORAGE R4 R4 was admitted for cares and services on November 11, 2019, with diagnosis to include cerebrovascular disease and other specified anemias. R4's service plan dated August 7, 2023, indicated R4 received services of complex medication administration. On August 30, 2023, at 8:00 a.m., the surveyor observed eight oxygen cylinders in R4's apartment. Five cylinders were secured in an oxygen storage crate, two cylinders were unsecured standing upright to the left of the oxygen storage crate, and one cylinder was in an oxygen rolling cart. On August 30, 2023, at 11:30 a.m., ULP-B stated "no" she did not recall being trained on how to store oxygen and was unsure of proper storage. On August 30, 2023, at 12:45 p.m., DON-A the licensee's oxygen storage policy "dictates what we should go by." DON-A further stated the oxygen company "may have left them out." The licensee's Nursing Delegated Tasks Oxygen Cylinder (Portable Tank) form dated February 7, 2017, indicated oxygen cylinders should always be kept in a stand or cart to prevent tipping. The Minnesota Department of Health Oxygen Cylinder Storage Requirements, dated April 16,2020, states, "cylinders must be secured (chains or racks) to prevent them from falling over." No further information provided.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20447	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLACE	3701 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 25 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *08/29/23*
Time: 11:15:15
Report: 1029231207

Food and Beverage Establishment Inspection Report

Location:

Walker Methodist Place
3701 Bryant Avenue South
Minneapolis, MN55409
Hennepin County, 27

Establishment Info:

ID #: 0039342
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128278500
ID #:

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

The following orders were issued during this inspection.

3-400B Destroying Organisims: reheating

3-403.11C ***** Priority 1 *****

MN Rule 4626.0360C Reheat TCS food that has been commercially processed and packaged in a food processing plant to a temperature of at least 135 degrees F (57 degrees C) for hot holding.

PASTA PRIMAVERA ABOUT TO BE HOT HELD MEASURED 125°F IN SOME AREAS. ITEM HAD BEGUN REHEATING 30 MIN PRIOR. INSTRUCTED OPERATOR TO REHEAT TO ADEQUATE TEMPERATURES PRIOR TO HOT HOLDING.

Comply By: 08/29/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

OUTPUT DRAINBOARD NEXT TO DISHWASHER NOT LEVEL AND NOT ALLOWING DISHWASHING RACKS TO OUTLET. SERVICE CALL PLACED WITH ENVIRONMENTAL SERVICES DURING INSPECTION TO CORRECT.

Comply By: 08/29/23

Surface and Equipment Sanitizers

QUATERNARY AMMONIUM: = 200 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

HOT WATER: = at 166 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Type: Full
Date: *08/29/23*
Time: 11:15:15
Report: 1029231207
Walker Methodist Place

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: TOMATO SOUP
Temperature: 41 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: HEAVY CREAM
Temperature: 38 Degrees Fahrenheit - Location: SERVER COOLER
Violation Issued: No

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

Inspection conducted of food services area as part of a Health Regulation Division survey.

Inspection conducted in the presence of Jacob Collins, ED of Culinary Services/CFPM, and other staff members. Topics discussed included highly susceptible populations, employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, sanitizing, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS foods).

Issues were communicated to Anna Bohnen, Nurse Evaluator, and Tammy Carlson, Nurse Evaluator, following the inspection.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029231207 of 08/29/23.

Certified Food Protection Manager: Jacob I. Collins
Certification Number: FM72753 Expires: 04/16/26

Signed: _____
Jake Collins
ED Culinary Services

Signed: _____
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231207

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 08/29/23
Time In 11:15:15
Time Out

Walker Methodist Place	Address: 3701 Bryant Avenue South	City/State: Minneapolis, MN	Zip Code: 55409	Telephone: 6128278500
License/Permit #: 0039342	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN (OUT) N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/29/23

Inspector (Signature) Trevor L McClimint