### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: DP0P

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY A	AGENCY	]	Facility ID: 27996
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245618  2.STATE VENDOR OR MEDICAID NO.     (L2)	3. NAME AND ADDRESS OF FACILITY (L3) WALKER METHODIST WESTWOOD I (L4) 61 THOMPSON AVENUE WEST (L5) WEST SAINT PAUL, MN		(L6) 55118		4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		04 (L7) 13 PTIP 22 CLIA		7. On-Site Visit 9. Other  8. Full Survey After Complaint			
6. DATE OF SURVEY 12/15/ 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	E	FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	37 (L18) 37 (L17)	B. Not in Com	nce With quirements		2. T 3. 2 4. 7 5. I	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code	Following Requirements:  6. Scope of Serv 7. Medical Direct 8. Patient Room 9. Beds/Room (L12)	cices Limit
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 37 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)	cis.	* Code: 15. FACILIT 1861 (e) (1)	A* Y MEETS ) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARK  17. SURVEYOR SIGNATURE	S (IF APPLICABLE S	HOW LTC CANCELL  Date:	ATION DATE):		18. STATE S	URVEY AGENCY APF	PROVAL	Date:
Sheryl Reed, H	IFE NE II	1	12/15/2016	(L19)	Kate J	ohnsTon, Pr	ogram Speciali	St 12/23/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE O	R SINGLE STATI	E AGENCY	
DETERMINATION OF ELIGIBILITY	icipate (L21)		IPLIANCE WITH C	IVIL	1		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF.	A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  11/21/2012	23. LTC AGREEMI BEGINNING I		24. LTC AGREEME ENDING DATE		26. TERMIN  VOLUNTARY  01-Merger, Cl		<u>INVOLUN</u>	L30) FARY eet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41)  27. ALTERNATIVE A. Suspension of B. Rescind Suspension	of Admissions:	(L25)		03-Risk of Inv	ction W/ Reimbursemen voluntary Termination son for Withdrawal	<u>OTHER</u>	Status Change
20. TEDMINIATION DATE.			(L45)		20 DEMARK	70		
28. TERMINATION DATE:	(L28)	00320	ANNIEN NU.	(L31)	30. REMARK	Δυ		
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE			TE	Posted	01/04/2017 Co.			
(L32) (L33)				(L33)	DETERMI	NATION APPROV	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 23, 2016

Ms. Brenda Schrupp, Administrator Walker Methodist Westwood Ridge II 61 Thompson Avenue West West Saint Paul, MN 55118

RE: Project Number S5618004

Dear Ms. Schrupp:

On December 15, 2016, a standard 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The Federal Form CMS-2567 is being electronically delivered.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

PRINTED: 12/23/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245618	B. WING _			12/	15/2016
	ROVIDER OR SUPPLIER	D RIDGE II		STREET ADDRESS, CITY, STATE, ZIP ( 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 000	A recertification surve December 12, 13, 14 Walker Methodist We to be in compliance w	ey was conducted , and 15, 2016. stwood Ridge II was found vith the requirements of 42 art B, and Requirements for				AI E	
ARORATORY	DIRECTOR'S OF PROVINCED	SUPPLIER REPRESENTATIVE'S SIGNATUR	PE PE	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.

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

¥5618005

Printed: 12/20/2016 FORM APPROVED OMB NO. 0938-0391

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

12/15/2016

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

(A4) ID SOMMET STATEMENT OF BEING MIST BE DESCRIBED BY SHALL BE CHILATORY DESCRIPTION (FACH CORRECTIVE ACTION SHOULD BE	****	WEST	WEST SAINT PAUL, MN 55118					
FIRE SAFETY  A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 15, 2016. At the time of this survey, Walker Methodist Westwood Ridge II was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.  Walker Methodist Westwood Ridge II is a 1-story building with no basement. The facility was constructed in 2012 and was determined to be of Type V(111) construction. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridors and is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 32 at time of the survey.  The requirement at 42 CFR, Subpart 483.70(a) is	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR)	Y PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE			
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		·						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DA	14808:5		NOMATURE	TITIE	(X6) DATE			

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