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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DSGX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27996

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
37				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 03/23/2015 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/21/2012
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/29/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 6, 2015

CMS Certification Number (CCN): 24-5618

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

Dear Ms. Schrupp:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 8, 2015 the above facility is certified for:

37 - Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Electronically Delivered: March 23, 2015

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

RE: Project Number S5618002 and FMS Project F5618003

Dear Ms. Schrupp:

On January 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 18, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 29, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F).

On February 9, 2015, the Minnesota Department of Health completed a health survey revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 18, 2014. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on December 18, 2014.

On February 10, 2015, CMS forwarded the results of the Life Safety Code (LSC) FMS and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory Denial of Payment for New Admissions Medicare effective March 18, 2015.

Also, the CMS Region V Office notified you in their letter of February 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation

Programs (NATCEP) for two years from March 18, 2015.

Additionally, on March 19, 2015, a surveyor representing the Minnesota Department of Public Safety completed an LSC PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an FMS survey, completed on January 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on this visit, MDH has determined that your facility has achieved substantial compliance with the LSC deficiencies issued pursuant to an FMS survey, completed on January 29, 2015.

As a result of the revisit findings, this Department recommended to CMS Region V Office the following actions related the remedy outlined in their letter of February 10, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory Denial of Payment for New Admissions Medicare effective March 18, 2015 be rescinded. (42 CFR 488.417(b))

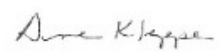
The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 18, 2015 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 18, 2015, is to be rescinded.

In the CMS letter of February 10, 2015, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 contact me if you have any questions about this electronic notice.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245618	A. Building B. Wing	2/9/2015

Name of Facility	Street Address, City, State, Zip Code
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **01/27/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **01/27/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/27/2015**
ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **01/27/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/27/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	03/23/2015	16022	02/09/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/18/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245618	A. Building B. Wing **01 - MAIN BUILDING**	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/08/2015**	ID Prefix	Correction Completed **02/23/2015**	ID Prefix	Correction Completed **03/08/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0014		Reg. # **NFPA 101** LSC K0018	
ID Prefix	Correction Completed **03/08/2015**	ID Prefix	Correction Completed **03/08/2015**	ID Prefix	Correction Completed **03/08/2015**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0045	
ID Prefix	Correction Completed **03/08/2015**	ID Prefix	Correction Completed **03/08/2015**	ID Prefix	Correction Completed **03/08/2015**
Reg. # **NFPA 101** LSC K0048		Reg. # **NFPA 101** LSC K0050		Reg. # **NFPA 101** LSC K0052	
ID Prefix	Correction Completed **03/08/2015**	ID Prefix	Correction Completed **03/08/2015**	ID Prefix	Correction Completed **03/08/2015**
Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0064		Reg. # **NFPA 101** LSC K0069	
ID Prefix	Correction Completed **03/08/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0073		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	03/23/2015	21012	03/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/29/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DSGX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27996

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
37				
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary C Heim, HPR-Social Work Specialist 01/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/21/2012
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5490

January 6, 2015

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

RE: Project Number S5618002

Dear Ms. Schrupp:

On December 18, 2014, 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. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 27, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original

deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by March 18, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 18, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified

for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 01/06/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	12/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Walker Methodist Westwood Ridge II provides innovative, technically competent, effective, sensitive, individualized care and programs. We value the dignity and uniqueness of each individual and strive to maintain their autonomy and independence while providing a safe and secure environment. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest of Facility, its Administrator or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	1/22/15 SER	

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

Campus Administrator — 1/14/15

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

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an allegation of mistreatment to the state agency and document the investigation thoroughly for 1 of 5 residents, (R231) reviewed for abuse prohibition. Findings include: R231's admission Minimum Data Set, (MDS), dated 12/14/14, indicated R231 was cognitively intact, had no signs of delirium, and required extensive assistance from one staff for transfers between surfaces. During standardized interview on 12/16/14 at 8:41 a.m., R231 was asked "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" R231 responded "yes" and added the person working with him when he first came in was rough with him. R231 reported he told the nurse in charge about the concern right away. During a follow up interview on 12/17/14 at 8:37 a.m., R231 reported	F 225	In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within 10 days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare program.	

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F 225	Continued From page 2 the person alleged to have been rough (AP) transported him into the building in a wheelchair upon his admission and bumped him into the wall multiple times. R231 reported he told the AP to slow down several times, but AP did not slow down. R231 reported he told the AP very clearly to be slow with his leg as he just had surgery. R231 reported AP went quickly and it seemed to be on purpose. R231 reported he never saw AP again. On 12/17/14 at 11:15 a.m. R231 reported the administrator just spoke with him about his concern regarding AP handling him roughly. R231 reported he felt foggy that day but knew there was a concern and felt the concern had been resolved. R231 could not recall who the AP was who handled him roughly. On 12/17/14 at 11:30 a.m. the administrator, director of nursing (DON) and nurse manager, (RN)-A reported they started the concern process and had no staff on duty who fit the description of the AP, as described by R231. The administrator reported the facility was previously unaware of the concern. On 12/17/14 at 3:48 p.m. RN-A reported it was determined the transport company transported R231. RN-A planned to follow up with the transport company about R231's concern. An Investigation Report, dated 12/17/14 revealed the facility interviewed R231 regarding his concern with the person who wheeled him in at admission. The investigation noted "Patient reported that the person who wheeled him to his room in his wheelchair bumped his leg into the wall two to three times. The patient then reported	F 225	The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegation of non-compliance or admission by Facility. RECEIVED JAN 20 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 225	Continued From page 3 that he was assisted to the bed. He was sitting at the edge of the bed and asked the assistant to move slowly when assisting with moving his legs into bed. The patient stated that this person did not move slowly when providing this assistance and his legs were placed one on top of the other. The patient remembers this occurring around 2pm, upon admission to the facility, and that the NAR [nursing assistant] was a "black man". The patient stated that the nurse came in right away as he was upset and the nurse gave him pain medications and that the situation "was taken care of and rapidly" The patient reported during our conversation with him that he does not trust what he is saying or what he remembers as his memory is a little foggy. He stated that he had some issues with what he remembered when he was in the hospital and that the pain medication he was taking caused these issues." A handwritten report attached to a Grievance Form recorded from the R231's statement, dated 12/17/14, revealed "Took him off van in w/c [wheelchair], person who took him to his room hit wall 2-3 times hit R [right] leg. He got me on the bed sideways. "You are going to have to go slow." The NAR just flopped me over. I started screaming." R231 also added "could have been the van driver. I was really out of it. Who knows who could have been." Both the Investigative Report and the Grievance Form with accompanying documentation indicated staff working on the day of the incident and R231 had been interviewed as part of the facility investigation. Neither the investigative report nor the Grievance Form and accompanying documents included a time the facility interviewed the staff or the full name of	F 225	F225 Administrator notified of concern for R231 on 12/17/14 and investigation started immediately. Interdisciplinary team reviewed concern and did not feel it was a reportable incident. After reviewing the grievance with surveyors, a VA report was made to MN Dept of Health on 12/18/14. R231 discharged from the facility on 1/1/15. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1) Whole house audit will be completed on any grievances of current residents to ensure that any allegation has been	1/27/15

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F 225	Continued From page 4 staff interviewed. Neither document included the questions the facility investigator asked staff or R231. On 12/18/14 at 1:15 p.m. RN-A reported she had not sent a report to the state agency regarding R231's allegation. RN-A reported she was not sure of the exact times interviews were conducted. RN-A reported she documented interviews directly in the investigative summary. RN-A reported she had provided survey team with all documentation from the investigation. On 12/18/14 the administrator reported the facility did not send a report of R231's allegation to the state agency. The administrator reported the facility did not feel the allegation needed to be reported because the resident reported he felt his recollection of the event may be foggy. The administrator reported the investigation was completed. The Vulnerable Adult Abuse Prohibition Plan, last revised 7/5/12, directed staff "A mandated reporter who has reason to believe that a VA [vulnerable adult] is being or has been maltreated, or has knowledge that a VA has sustained a physical injury which is not reasonably explained will report the information to the CEP [common entry point] and the Minnesota Department of Health as soon as possible, but no more than 24 hours after discovery of the incident." The policy further directed staff "f. Interview possible perpetrators, witnesses or individuals who may have knowledge of the injury or accident. This may include residents, staff, visitors, vendors or others. g. The scope of the investigation will be determined by taking into consideration the nature and appearance of any	F 225	thoroughly investigated and reported appropriately. 2) Weekly audits will be completed of any new grievances to ensure that any allegation has been thoroughly investigated and reported appropriately. The Vulnerable Adult Abuse Prohibition Plan-Skilled Policy will be reviewed and updated by Administrator or designee. All staff will be educated on policy by Administrator or designee. All information will be brought to QA by Administrator or designee to discuss findings and need for further auditing. Date of completion: January 27, 2015	

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F 225	Continued From page 5 injuries, the date the report is received vs. [versus] the date the incident may have occurred and any other pertinent information collected. h. All interviews are documented and placed in the investigation file. i. Pertinent medical record information is copied and placed in the investigative file. j. Work schedules of volunteers or staff who my have been involved are reviewed, copied and placed in the investigative file."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy and immediately report an allegation of mistreatment to the state agency and document the investigation thoroughly for 1 of 5 residents (R231) reviewed for implementation of abuse prohibition policy. Findings include: The Vulnerable Adult Abuse Prohibition Plan, last revised 7/5/12, directed staff "A mandated reporter who has reason to believe that a VA [vulnerable adult] is being or has been maltreated, or has knowledge that a VA has sustained a physical injury which is not reasonably explained will report the information to the CEP [common entry point] and the Minnesota	F 226	F226 Administrator notified of concern for R231 on 12/17/14 and investigation started immediately. Interdisciplinary team reviewed concern and did not feel it was a reportable incident. After reviewing the grievance with surveyors, a VA report was made to MN Dept of Health on 12/18/14. R231 discharged from the facility on 1/1/15.	1/27/15

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F 226	Continued From page 6 Department of Health as soon as possible, but no more than 24 hours after discovery of the incident." The policy further directed staff "f. Interview possible perpetrators, witnesses or individuals who may have knowledge of the injury or accident. This may include residents, staff, visitors, vendors or others. g. The scope of the investigation will be determined by taking into consideration the nature and appearance of any injuries, the date the report is received vs. [versus] the date the incident may have occurred and any other pertinent information collected. h. All interviews are documented and placed in the investigation file. i. Pertinent medical record information is copied and placed in the investigative file. j. Work schedules of volunteers or staff who my have been involved are reviewed, copied and placed in the investigative file." R231's admission Minimum Data Set (MDS), dated 12/14/14, indicated R231 was cognitively intact, had no signs of delirium, and required extensive assistance from one staff for transfers between surfaces. During standardized interview on 12/16/14 at 8:41 a.m., R231 was asked "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" R231 responded "yes" and added the person working with him when he first came in was rough with him. R231 reported he told the nurse in charge, who was male, about the concern right away. During a follow up interview on 12/17/14 at 8:37 a.m., R231 reported the person alleged to have been rough (AP) transported him into the building in a wheelchair upon his admission and bumped him into the wall multiple times. R231 reported he told the AP to slow down several times, but AP	F 226	Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1) Whole house audit will be completed on any grievances of current residents to ensure that any allegation has been thoroughly investigated and reported appropriately per our facility policy. 2) Weekly audits will be completed of any new grievances to ensure that any allegation has been thoroughly investigated and reported appropriately per our facility policy.	

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F 226	Continued From page 7 did not slow down. R231 reported he told the AP very clearly to be slow with his leg as he just had surgery. R231 reported AP went quickly and it seemed to be on purpose. R231 reported he never saw AP again. On 12/17/14 at 11:15 a.m. R231 reported the administrator came just spoke with him about his concern regarding AP handling him roughly. R231 reported he experienced foggy thinking that day but knew there was a concern and felt the concern had been resolved. R231 could not recall who the AP was who handled him roughly. On 12/17/14 at 11:30 a.m. the administrator, director of nursing (DON) and nurse manager, (RN)-A reported they started the concern process and had no staff on duty who fit the description of the AP, as described by R231. The administrator reported the facility was previously unaware of the concern. On 12/17/14 at 3:48 p.m. RN-A reported it was determined the transport company transported R231. RN-A planned to follow up with the transport company about R231's concern. An Investigation Report, dated 12/17/14 revealed the facility interviewed R231 regarding his concern with the person who wheeled him in at admission. The investigation noted "Patient reported that the person who wheeled him to his room in his wheelchair bumped his leg into the wall two to three times. The patient then reported that he was assisted to the bed. He was sitting at the edge of the bed and asked the assistant to move slowly when assisting with moving his legs into bed. The patient stated that this person did not move slowly when providing this assistance	F 226	The Vulnerable Adult Abuse Prohibition Plan-Skilled Policy will be reviewed and updated by Administrator or designee. All staff will be educated on policy by Administrator or designee. All information will be brought to QA by Administrator or designee to discuss findings and need for further auditing. Date of completion: January 27, 2015	

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F 226	Continued From page 8 and his legs were placed on on top of the other. The patient remembers this occurring around 2pm, upon admission to the facility, and that the NAR [nursing assistant] was a "black man". The patient stated that the nurse came in right away as he was upset and the nurse gave him pain medications and that the situation "was taken care of and rapidly" The patient reported during our conversation with him that he does not trust what he is saying or what he remembers as his memory is a little foggy. He stated that he had some issues with what he remembered when he was in the hospital and that the pain medication he was taking caused these issues." A handwritten report attached to a Grievance Form recorded from the R231's statement, dated 12/17/14, revealed "Took him off van in w/c [wheelchair], person who took him to his room hit wall 2-3 times hit R [right] leg. He got me on the bed sideways. "You are going to have to go slow." The NAR just flopped me over. I started screaming." R231 also added "could have been the van driver. I was really out of it. Who knows who could have been." Both the Investigative Report and the Grievance Form with accompanying documentation indicated staff working on the day of the incident and R231 had been interviewed as part of the facility investigation. Neither the Investigative Report nor the Grievance Form and accompanying documents included a time the facility interviewed the staff or the full name of staff interviewed. Neither document included the questions the facility investigator asked staff or R231. On 12/18/14 at 1:15 p.m. RN-A reported she had	F 226		

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F 226	Continued From page 9 not sent a report to the state agency regarding R231's allegation. RN-A reported she was not sure of the exact times interviews were conducted. RN-A reported she documented interviews directly in the investigative summary. RN-A reported she had provided survey team with all documentation from the investigation. On 12/18/14 the administrator reported the facility did not send a report of R231's allegation to the state agency. The administrator reported the facility did not feel the allegation needed to be reported because the resident reported he felt his memory may be foggy. The administrator reported the investigation was completed.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a weekly body audit form as directed by the care plan and facility policy for 1 of 3 residents (R224) reviewed for pressure ulcers. Findings include: Review of R224's Minimum Data Set (MDS) revealed an admission date of 11/10/14. A pressure ulcer care plan, dated 11/25/14, directed staff to inspect skin daily during cares	F 282	F282 R224 discharged from the facility on 1/2/15. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1) Whole house audit will be completed to ensure weekly body audits are completed.	1/27/15

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F 282	Continued From page 10 and to monitor skin during baths and weekly due to risk of pressure ulcer development from diagnoses including congestive heart failure (CHF), leg edema, confusion, weakness, peripheral neuropathy, anemia, use of a urinary Foley catheter and chronic kidney disease (CKD). An admission body audit, dated 11/10/14 identified R224 had no pressure ulcers. A review of the the Weekly Body Audit tool for November and December 2014, lacked documented information that scheduled body audits had been completed for 11/23/14, 11/30/14 and 12/13/14. Physician Orders, dated 12/16/14, revealed a diagnoses of a deep tissue injury on 11/26/14. (A deep tissue injury is a localized area of discolored, darker than surrounding tissue, intact skin or blood-filled blister related to damage of underlying soft tissue from pressure and/or shear. Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) On 12/18/2014 at 10:12 a.m. the registered nurse (RN)-E confirmed nurses had not completed the weekly body audit forms for R224. Although the nurse initialed the weekly body audits were completed in the medication and treatment administration records, RN-E's expectation was for staff to complete the weekly body audit paper forms. The policy and procedure titled, Skin and Wound Care revised 1/27/14 directed staff to complete a weekly body audit on the resident's bath day.	F 282	2) All new admissions will be reviewed to ensure the admission body audit is completed. 3) 10 Residents will be randomly audited per week to ensure body audits are complete. The Skin and Wound Care – EHR and Weekly Body Audit Policies will be reviewed and updated by Director of Nursing or designee. All licensed nursing staff will be educated on policies by Director of Nursing or designee. All information will be brought to QA by Director of Nursing or designee to discuss findings and need for further auditing. Date of completion: January 27, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	12/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332 F 332 SS=D	Continued From page 11 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to administer 2 medications without error to 1 of 5 residents (R226). Based on 26 medication opportunities this resulted in an error rate greater than 5% at 7.69%. Findings include: R226 was admitted 12/3/14 with , Chronic obstructive pulmonary disease (COPD). The physician orders, dated 12/3/14, directed staff to administer Spiriva 18 mcg (micrograms) inhalation capsule, inhale one capsule by mouth daily(qd) and Advair 500/50 mcg, inhale 1 puff 2 times a day. The physician orders did not identify which inhaler to give first. During observation on 12/16/14 between 8:08 and 8:29 a.m. registered nurse (RN)-F was observed administering medications for R226. First, RN-F administered the Spiriva inhaler followed immediately by administration of the Advair inhaler. (Spiriva, tiotropium bromide inhalation powder is a prescription medicine used once each day as a maintenance medicine to control symptoms of chronic obstructive pulmonary disease (COPD) by relaxing airways and keeping them open. Advair contains	F 332 F 332	F332 R226 discharged from the facility on 12/18/14. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1) Whole house audit will be completed to ensure any resident on inhalers has proper orders for administration. 2) All new admissions will be reviewed to ensure any resident on inhalers has proper orders for administration. 3) All licensed nursing staff will demonstrate competency on administering inhalers.	1/27/15

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	245618	A. BUILDING _____ B. WING _____	12/18/2014

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

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F 332	Continued From page 12 fluticasone and salmeterol. Fluticasone is a steroid. Advair prevents the release of substances in the body that cause inflammation. Salmeterol is a bronchodilator. It works by relaxing muscles in the airways to improve breathing.) After administering Advair, RN-F gave R226 a glass of water, which R226 drank. On 12/16/14 right after the observation at 8:35 a.m. RN-F confirmed she administered the Spiriva inhaler and then immediately the Advair inhaler instead of waiting at least a minute between administering two inhalers. RN-F also acknowledged after the steroid inhaler she should have directed R226 to rinse and spit out the contents. On 12/16/2014, at 12:16 p.m. the consultant facility pharmacist reported, after administration of a steroid inhaler, staff should have the resident rinse with water and spit out the contents afterwards. The staff should also wait in between puffs at least 1 minute. On 12/16/2014 at 3:09 p.m., registered nurse manager, (RN)-E, thought the staff should wait 5 minutes in-between inhalers and staff should have the resident rinse mouth with water and spit out the contents. The undated facility policy and procedure titled, Orally Inhaled Medications, directed staff "Wait approximately 1 minute between inhalations or as ordered by the physician or according to manufacturers recommendations."; "If 2 or more inhalers are prescribed at the same time ask physician which should be given first." and "Rinsing the mouth is the most commonly recommended for long term steroid use."	F 332	4) 3 observations of inhaler administration will be randomly completed per week of residents on scheduled inhalers. The Orally Inhaled Medications Policy will be reviewed and updated by Director of Nursing or designee. All licensed nursing staff will be educated on policy by Director of Nursing or designee. All information will be brought to QA by Director of Nursing or designee to discuss findings and need for further auditing. Date of completion: January 27, 2015	

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	245618	A. BUILDING _____ B. WING _____	12/18/2014

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	F431 R239 discharged on 12/22/14. R227 discharged on 12/23/14. R236 discharged on 12/22/14. R245 discharged on 12/26/14. R36 discharged on 12/18/14. R224 discharged on 1/2/15. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1) Whole house audit will be completed of all 3 med rooms and 3 med carts to ensure that all multi-dose containers are labeled and dated appropriately when opened.	1/27/15

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	245618	A. BUILDING _____ B. WING _____	12/18/2014

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

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F 431	Continued From page 14 review the facility failed to date insulin vials (injectable diabetes medications) when opened for 5 of 6 residents (R239, R227, R236, R245, R36) who received insulin and R36 received insulin beyond the expiration date. Eye medication bottles were not dated when opened for 2 of 2 residents (R236, R224) who used eye drops and stock Tubersol (a diagnostic antigen used to aid in the detection of infection with the Mycobacterium tuberculosis) and Fluvirin, (influenza virus vaccine) vials were opened and not dated. Findings include: On 12/15/2014 at 11:53 a.m., all three medication carts and all three medication rooms were checked for opened, dated and expired medications. The following was observed in the medication carts: R239's Novolog insulin, with a pharmacy date on the label of 12/10/14, was opened by staff and not dated as to when it was open. Lantus insulin, with a pharmacy date on the label of 12/10/14, was open and was not dated as to when it was opened. R227's Humalog insulin, with a pharmacy date on the label of 12/3/14, was open and not dated as to when it was opened. R236's Novolog insulin, with a pharmacy date on the label of 12/5/14, was open and not dated as to when it was opened. Lantus insulin, with a pharmacy date of 12/5/13, was open and not dated as to when it was opened.	F 431	2) 3 Audits of different areas will be completed randomly per week to ensure that all multi-dose containers are labeled and dated appropriately when opened. The Multi-Dose Vials and Large Volume Sterile Solutions Policy will be reviewed and updated by Director of Nursing or designee. All licensed nursing staff will be educated on policy by Director of Nursing or designee. All information will be brought to QA by Director of Nursing or designee to discuss findings and need for further auditing. Date of completion: January 27, 2015	

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	245618	A. BUILDING _____ B. WING _____	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 15 R245's Lantus insulin, with a pharmacy date of 12/14/14, was open and had no date as to when it was opened. R36's Novolog insulin, with a pharmacy label date of 11/7/14, was open and had no date indicating when it had been opened. On 12/15/14 at 12:45 p.m., registered nurse (RN)-D indicated the Novolog insulin had been given as a sliding scale dosage of insulin that morning. R236's Travatan eye medication (to help reduce the elevated pressure inside the eye), which had a specific expiration date, was not dated when opened. It had a pharmacy label on it which read 12/5/14. R224's Xalatan eye medication (to treat high eye pressure) had a pharmacy label which read 11/5/14. It was not dated as to when it had been opened. In the medication room refrigerators a total of four Tubersol vials and one vial of Fluvirin were observed open and not dated. There were no pharmacy labels to indicate when the vials were dispensed from the pharmacy. When interviewed on 12/15/2014, at 12:23 p.m., the nurse manager, (RN)-E indicated the facility policy was to date all medications when opened, which included all multidose containers such as eye medications, and insulin vials. On 12/15/2014 at 1:11 p.m., RN-E indicated outdated insulin should not be given and medications should be dated when opened. At 2:00 p.m., RN-E provided R36's medication	F 431		

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	245618	A. BUILDING _____ B. WING _____	12/18/2014

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F 431	Continued From page 16 administration record and explained, R36 was given the expired insulin at least 30 times. RN-E said even though the pharmacy label may have a recent date on the label, all insulin vials must be dated when opened to help the facility and resident avoid administering outdated medications. On 12/16/2014 at 11:52 a.m., the consultant pharmacist reported insulin vials needed to be dated when open. The 2 eye drops (Travatan, Xalatan) should be dated when opened as they were not to be given beyond 45 days of being open. The policy and procedure dated 6/28/12, titled Multidose Vials and Large Volume Solutions directed staff : "Multiple dose containers are dated when opened." and "The expiration for insulin is 30 days, due to potency reasons."	F 431		

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	245618	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**12/17/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, WALKER METHODIST WESTWOOD RIDGE II was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New 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 protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 35 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		

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