

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 5, 2021

Administrator Walker Methodist Health Center 3737 Bryant Avenue South Minneapolis, MN 55409

RE: CCN: 245055

Cycle Start Date: December 7, 2020

Dear Administrator:

On December 29, 2020, we notified you a remedy was imposed. On January 25, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 20, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective January 13, 2021 be discontinued as of January 20, 2021. (42 CFR 488.417 (b))

Also, we notified you in our letter of December 29, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 13, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 12, 2021

Administrator Walker Methodist Health Center 3737 Bryant Avenue South Minneapolis, MN 55409

RE: CCN: 245055

Cycle Start Date: December 7, 2020

Dear Administrator:

On December 29, 2020, we informed you of imposed enforcement remedies.

On December 28, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 13, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 13, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of December 29, 2020, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 13, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

- 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).

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor

Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220

P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: sarah.grebenc@state.mn.us

Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 7, 2021 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 01/20/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245055	B. WING			C 12/28/2020	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	20/2020
					3737 BRYANT AVENUE SOUTH		
WALKER	R METHODIST HEALT	TH CENTER			MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		ΕC	000			
F 000	was conducted from at your facility by the Health to determine Preparedness regulated facility was IN full of Because you are esignature is not requage of the CMS-2 correction is require acknowledge receil INITIAL COMMENT. From 12/23/20 thresurvey was comple complaint investigated NOT to be in compresurvey was comple complaint investigated and Interest of the following compresuration of the following compression of the following comp	nrolled in ePOC, your quired at the bottom of the first 1567 form. Although no plan of ed, it is required that the facility pt of the electronic documents. TS ough 12/28/20, an abbreviated eted at your facility to conduct a ation. Your facility was found eliance with 42 CFR Part 483, and Term Care Facilities. Dlaint was found to be 1H5055264C/MN68329, with a 1H5055265C/MN68399. Seed Infection Control survey d from 12/23/20 through acility by the Minnesota alth to determine compliance ion Control. The facility was IN of correction (POC) will serve of compliance upon the	FO	000			
L ABORATOR'	V DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

Electronically Signed 01/18/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245055	B. WING		C 12/28/2020	
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	1 2012	10,2020
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F 000	Because you are er signature is not req page of the CMS-29 submission of the F verification of comp	orrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as	F 00	0		
	validate that substa	ntial compliance with the en attained in accordance with	F 69	2		1/20/21
	(Includes naso-gast both percutaneous percutaneous endo enteral fluids). Bas	essment, the facility must				
	of nutritional status, desirable body weig balance, unless the	tains acceptable parameters such as usual body weight or pht range and electrolyte resident's clinical condition his is not possible or resident e otherwise;				
	§483.25(g)(2) Is off maintain proper hyd	ered sufficient fluid intake to dration and health;				
	there is a nutritional provider orders a the This REQUIREMEN by:	NT is not met as evidenced				
	Based on interview	and document review, the		Resident R1 was transferred to the	he	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245055	B. WING			28/2020	
NAME OF	PROVIDER OR SUPPLIE	 R		STREET ADDRESS, CITY, STATE, 2		20/2020	
				3737 BRYANT AVENUE SOUTH			
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F 692	evaluation/assess decline of nutrition residents (R1) revent hydration. This revent was admitted to the pneumonia and dintravenous hydrates. The findings include: R1 was admitted pre-admission his notes indicated R or taking medicate care and hospice declined hospice. R1's admission M 12/10/20, identificing impairment and rewith eating. The M symptoms of posting diagnosis include metabolic enception caused by chemic renal insufficiency kidneys lose abiliting R1's nutritional as identified R1 requirements.	replement an ordered swallow sment which resulted in a n and hydration status for 1 of 3 viewed for nutrition and sulted in actual harm when R1 he hospital with sepsis, ehydration that required ation and nutrition therapy. to the facility on 12/4/20. R1's story and physical progress 1 had not been eating, drinking ions. R1 had received palliative evaluations but R1's family	F 6		on December 14, I Hydration have ain current. I'll re-educate assistants, hydration and has identified and to have an intake, and or a onal intake as ciplinary team. Heen audited and orders for Speech appleted and apy assessments aneeded, and that umentation. I age Pathology will age Pathology will their how they will us throughout their		
	swallowing. The completed by the reviewed progres family. The nutriti	difficulties with chewing or nutritional assessment was dietary technician (DT) who s notes and spoke with R1's onal assessment did not include e observations of R1 by the DT		This change will go into In addition we have retro reviewed admissions sin have identified those wit documentation of their Sand will enter late entry	o-actively nce 12/31/20, and shout Speech screen,		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG		E SURVEY PLETED
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				3737 BRYANT AVENUE SOUTH		
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F 692	a nutritional proble problem and instrand report any sig (difficulty swallowing further instructed and make diet chaneeded. R1's physician ord "SLP: Eval and Toto evaluate and transition or "Provide 120 cc [contrition supplemed Document [percendietician] if pt. reful R1's progress not indicated R1 did rebecause she "can throws away food R1's progress not indicated, "Patient breakfast. Will spit together at times, and drank 60 cc cospoke with [R1's fintakeRefusing stated patient like few bites at a time a while later. NP [updated on status]	cian (RD). ciated 12/4/20, identified R1 had em or potential nutritional ucted staff to monitor, document ans or symptoms of dysphagia ang) or refusal to eat. Care plan registered dietician to evaluate ange recommendations as der dated 12/4/20, indicated, a [speech-language-pathologist eat]." der dated 12/7/20, indicated, cubic centimeters] HNS [house ent] TID [three times a day]. nt] intake. Notify RD [registered uses [times] 3." es dated 12/6/20, at 8:59 a.m. not receive ordered medication 't swallow" and "pushed and	F6	with the above data and per additional assessments as a Speech Language Patholog educated that the expectation provider orders an evaluation that cannot be completed, the notify the provider and docucommunication in Point Click. When Speech Language Pareceives an order for evaluation cannot be completed, they approvider to notify of findings document this communication Click Care. Interdisciplinary teams were monitoring and reporting nuconcerns for all residents and concerns to providers and of Therapy. Concerns will be refollowed via Clinical and ID. We will audit all incoming and check for Speech Progress period of 2 months, at which audits will be shared at the Center so Quality Assurance meeting to determine ongoin. We will audit interdisciplinar meeting notes 3 times a well-provider was contacted for a period at which time the audits will.	needed. Ity will be on, when a on by Speech he SLP will ament that ek Care. Athology ation that will contact the and on in Point The educated on tritional status and reporting or Speech noted and and the form of the form of the educated on the tritional status and reporting or Speech noted and the form of the educated on time the Health egroup and frequency. The tritional status are the educated on the educated on the educated on the educated on the educated of the educ	

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	PROVIDER OR SUPPLIER	H CENTER		37	REET ADDRESS, CITY, STATE, ZIP CODE 37 BRYANT AVENUE SOUTH INNEAPOLIS, MN 55409	1 121	2012020
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F 692	indicated, "Patient of meals." R1's progress note indicated, "Patient of meals." R1's progress note indicated, "She has to open mouth, clin pushing away staff Exhibited the same R1's progress note indicated, "Pt has pushing and pushing away staff exhibited the same indicated, "Pt has pushing away staff exhibited the same indicated, "She refundicated,	s dated 12/8/20, at 2:00 p.m. only taking a few bites at s dated 12/9/20, at 1:17 p.m. only taking a few bites at dated 12/10/20, at 9:12 p.m. onto been eating well, unable ched her teeth during meals or hand when been [sic] fed. behavior with med intake." dated 12/11/20, at 1:40 p.m. ooor diet intake." dated 12/12/20, at 8:43 p.m. used both meds and en mouth, clinched her teeth shing away staff hand when	F 6:	92	group meeting to determine ongoin frequency. Director of Rehab or designee will complete audits of Speech Langua Pathology Progress Notes. DON or designee will be responsib complete audits of interdisciplinary meeting notes and communication progress notes to ensure providers contacted when nutritional needs changed.	ge le to team	
	R1's progress note late entry dated 12/14/20, at 9:47 a.m. indicated nurse practitioner was updated on "patient not eating and only taking sips of fluids." R1's progress note dated 12/14/20, at 8:20 p.m. indicated "writer went to take pt her medication and she noted that pt was unable to swallow and that pt was not responding to verbal stimuli. Pt was not opening her eyes and periodically pt's arms and body will shake. Pt had shallow breathing RR [respiratory rate] 28 B/P [blood pressure] 103/63 P [pulse] 89 Oxygen 62-75% on RA [room air]. Oxygen administration was						

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F 692	NC [nasal cannula was present in the and she stated," I was chance and stated comfort cares." [F-[F-B] who also indivinterventions and the seen physically calland was updated family wishes and at 1857 [6:57 p.m.] called Pt left the stretcher with the ER1's Nutrition Amount Drank receintake on two days days. The remaining indicated R1 consucc.	age 5 kygen came up to 95% on 2L]. Writer updated [F-A] who room about her mom's status want to give her a fighting that she is not ready for A] was also on the phone with cated that they want immediate hat they wanted their mother to by the doctor. Writer paged on ated of the pt's status and pt's she stated to send pt to the ER [Emergency services were facility at 1923 [7:23 p.m.] on a EMT [for the hospital]." unt Eaten record for 12/5/20 andicated R1 ate 0-25% of meal of meal 1 time, 51-75% of meal ed four times. R1's Nutrition ord indicated R1 had no fluid and 120 cc or less on four three days, R1's record umed 720 cc, 300 cc and 150 on 12/23/20, at 1:36 p.m.	F 69	2		
	family member (F) video chat on 12/9, very dry mouth and stated she spoke very member at the facility proso that F-A could very 12/12/20. On 12/14 poor intake and wardinner on that day eat. F-A stated she 5:15 p.m. and atter	-A stated she saw R1 in a /20, and described R1 had "a d lips sticking together." F-A with an unidentified staff ility who encouraged her to wided essential caregiver class isit R1. F-A took the class on 4/20, F-A was informed of R1's as encouraged to visit R1 for to see if F-A could get R1 to a arrived at the facility at about mpted to assist R1 with the tated the food and beverage				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 692	anything that visit. If unresponsive" and stated when registed saw R1, RN-A seer condition and said time she worked with obtained a set of virus (blood oxygen level placed oxygen on Ferrick stated paramedics have made it through the hospital when seen and told R1 was not seen at the progress and the progress notes to cassessment. RD stated progress notes to casses notes to ca	th. F-A never saw R1 swallow F-A described R1 as "totally with a "very dry mouth." F-A ered nurse (RN)-A came in and med surprised at R1's R1 was not like this the last th her on 12/11/20. RN-A tal signs and R1's O2 sats 1) were 65%. RN-A then R1. A decision was made to pital and 911 was called. F-A told her R1 probably would not gh the night if R1 did not go to he did. F-A stated R1's use she did not eat or drink. The either she or other family d the facility two times a day mission for updates and were to eating or drinking. The eating or drinking. The eating or drinking and the facility on did that she reviewed R1's complete the admission atted she must have missed atted R1 had not taken not being able swallow. RD otified that R1 did not take the upplement and that "in a would expect to be notified of m staff as soon as they were ted that notification did not	F 6	92		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245055	B. WING			C 12/28/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT 3737 BRYANT AVENU MINNEAPOLIS, MN	IE SOUTH	1212	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	'S PLAN OF CORRECTIOI ECTIVE ACTION SHOULD ENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	not even open her 12/6/20] the report she don't [sic] drink medication she wo would not respond the normal process provider and speed not eating. RN-B shecause she thougaware. RN-B state document the residhealth record (EHF supposed to assess resident's intake. When interviewed RN-C stated that shand they typically sof admission. "Even and nutrition assess reasonable amoun upon admission Rarefused food. RN-C therapist (ST) and someone did not experiment dated 12 why R1 did not recomplete an in-per resident and would resident was unable stated the nurse shands and the shands and they typically sof admission. "Even and nutrition assess reasonable amount upon admission Rarefused food. RN-C therapist (ST) and someone did not experiment dated 12 why R1 did not recomplete an in-per resident and would resident was unable stated the nurse shands are identified. RN were identified. RN would resident stated the state of the	age 7 Id not eat or drink and would mouth. "When I came [to work I got said she don't [sic] eat k. When I tried to give her uld not open her mouth and to conversation." RN-B stated is would be to notify the RD, the ch therapy when a resident was tated she did not notify anyone ght everyone was already did the nursing assistants (NAs) dent's intake into the electronic R) and the nurses were so the resident and review the see a resident within 24 hours in through Covid all therapy soments were being done in a tof time." RN-C stated that I had difficulty to swallow and C further stated the speech RD should be notified when at. RN-C verified R1 had an alreapy evaluation and 2/4/20, and could not explain eive that evaluation. RN-C R1's nutrition assessment of have any difficulty to son assessment with the I contact the family if the let to communicate. RN-C includ notify dietary and the INP) when intake concerns I-C further stated R1 was spital on 12/14/20, for	F 6	92			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245055	B. WING _		12	C / 28/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	•	720/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 692	F 692 Continued From page 8		F 69	92		
		dministration and an elevated N-C further stated, "Elevated es dehydration."				
		o contact the nurse practitioner for R1 were unsuccessful.				
	stated she did not why she was not norder. ST stated the clinical coordinator for speech or swal she always enters when she saw a re- no progress note for reviewing R1's EH definitely seen R1 indicated concerns	on 12/28/20, at 11:05 a.m. ST see R1 and could not explain otified of the speech evaluation at Monday through Friday, the is notify ST of any new orders low therapy. ST further stated a progress note into the EHR esident and verified there was from her in R1's chart. While R, ST stated she would have as the progress notes when R1 swallowed.				
		the clinical coordinators were therefore, they were erview.				
	dietary technician complete the initia within the first thre "I usually go and s not going to be able the family." DT coudid talk to R1's fan completion of the i 12/7/20. "I just wer to the family. I loo see the 'can't swal DT stated she woutherapy had she see	on 12/28/20, at 11:21 a.m. (DT) stated that she would I resident nutrition assessment e days of admission. DT stated ee the resident and if they are e to communicate, then I calluld not recall if R1 was seen but nily member. DT verified nitial nutrition screen for R1 on ht by the chart and then talked ked at the chart and did not low' documented on 12/6/20." all dhave contacted speech een that. "I did take the poor deration and that is why we				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245055	B. WING _		l	/28/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 692	started her on the was supposed to scomplete admission five days of the initiative been 12/12/2 attempt to visit [the communicate with when interviewed assistant director of RD or DT would do all residents within admission. ADON be done in person communicate, other	HNS." DT stated, "The RD see the resident and do a on nutrition assessment within cial nutrition screen which would 0, for R1. "The RD should first e resident] and then	F 69	2		
	supposed to run a notes for the previous noted from the rep discussed in the di which dietary was stated any swallow been discussed in team) meetings as	report and review all progress ous 24 hours. Any concerns ort or notes should have been ally (M-F) clinical meeting in always present. ADON further ving concerns should have the unit IDT (interdisciplinary well. ADON verified R1's nent dated 12/7/20, did not				
	indicated R1's adn severe sepsis, pne kidney injury. R1's	ssion note dated 12/14/20, nission diagnoses included eumonia, dehydration and acute Creatinine was 3.25 mg/dl ciliter) (normal Creatinine range 2 mg/dl).				
	note dated 12/23/3 intake was "not on cognitive status bu	py hospital inpatient progress 60 indicated, R1's lack of oral ly related to refusals/her it also related to the swallow s physical oral motor abilities				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245055	B. WING _			C 12/28/2020	
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		20,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	do not allow her to trigger any function evaluation dated 12 therapy would follow intake trials as able. The facility policy Not revised 12/31/18, in nutritional assessment evaluate nutrition at three business days must complete an Interview/Screen. To Nutrition Assessment of the complete date of the complete date of the complete o	manipulate food or liquid or al swallow." A clinical swallow 2/17/20, indicated speech w R1 daily and attempt oral structuration Assessments last dentified a comprehensive ent was to be used to and hydration risks. Within s of admission, an RD or DT nitial Nutrition the RD should complete a ent upon admission using of and communication with the ential resources, licensed and all shifts] physician, family and consultants as appropriate	F 69	92			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 5, 2021

Administrator Walker Methodist Health Center 3737 Bryant Avenue South Minneapolis, MN 55409

Re: Reinspection Results

Event ID: HWDV12

Dear Administrator:

On January 25, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 7, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kamala Fiske Downing

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 12, 2021

Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, MN 55409

Re: State Nursing Home Licensing Orders

Event ID: HWDV11

Dear Administrator:

The above facility was surveyed on December 23, 2020 through December 28, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Sarah Grebenc, Unit Supervisor Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: sarah.grebenc@state.mn.us

Office: (651) 201-3792

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 01/20/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICATI	SUPPLIER/CLIA ION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
							;
		00276		B. WING		12/2	8/2020
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER		ANT AVENU			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		IENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION	ORDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain	ction order has y. If, upon rein iency or deficie ected, a fine for be assessed in ines promulgat artment of Heal compliance with rule provided alle number indicas several item	been issued spection, it is noies cited each violation accordance ed by rule of lth. on has been all eat the tag cated below. s, failure to				
	comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	Lack of comp ny item of mult ment of a fine of	liance upon i-part rule will even if the item				
	You may request a that may result from orders provided that the Department with notice of assessment.	n non-complian t a written requ hin 15 days of r	ce with these est is made to eceipt of a				
	INITIAL COMMENT On 12/23/20 throug survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you and identify the date	h 12/28/20, an ted to determin e. Your facility v with the MN St our electronic p have reviewed	e compliance was found to be tate Licensure. blan of these orders,				

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

Electronically Signed 01/18/21

TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00276	B. WING		12/2) 8/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WALKER	METHODIST HEALT	H CENTER	ANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: licensing order issu The following comp UNSUBSTANTIATE The facility is enrolled.	laint was found to be H 5055264 C/MN68329 with a ed. laint was found to be ED: H5055265C/MN68399 ed in ePOC and therefore a uired at the bottom of the first				
2 945	MN Rule 4658.0530 Eating - Nursing Pe	Subp. 1 Assistance with rsonnel	2 945			1/20/21
	personnel must det served diets as preshelp in eating must receipt of the meals unhurried and in a renhances each residential eating. Food and flucture observed and dereported to the nurs resident's care during observation of a deriver the diet of the served and dereported to the nurs resident's care during observation of a deriver the diet of the served and dereported to the nurs resident's care during observation of a deriver the served and dereported to the nurs resident's care during the served and dereported to the served and d	g personnel. Nursing ermine that residents are scribed. Residents needing be promptly assisted upon and the assistance must be manner that maintains or ident's dignity and respect. devices must be provided to sident's independence in uid intake of residents must eviations from normal se responsible for the ng the work period the viation was made. Persistent as must be reported to the n.				
	by: Based on interview facility failed to impl	and document review, the lement an ordered swallow nent which resulted in a		Correction date on or before Janua 2021.	ary 20,	

Minnesota Department of Health

STATE FORM 6899 HWDV11 If continuation sheet 2 of 11

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 (CA) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 945 Continued From page 2 decline of nutrition and hydration status for 1 of 3 residents (R1) reviewed for nutrition and hydration. This resulted in actual harm when R1 was admitted to the hospital with sepsis, pneumonia and dehydration that required intravenous hydrations but R1's family declined hospice care. R1's admission Minimum Data Set (MDS) dated, 12/10/20, identified R1 with severe cognitive impairment and required extensive assistance with eating. The MDS indicated no signs or symptoms of possible swallowing disorder. R1's diagnosis included on Alzheimer's dementia, metabolic encephalopathy (a problem in the brain caused by chemical imbalance in the blood) and renal insufficiency (a condition in which the kidneys lose ability to remove waste). R1's nutritional assessment dated 12/7/20,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
WALKER METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 CALL DESCRIPTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG PREFIX TAG PR			00276	B. WING		l l	
SUMMARY STATEMENT OF DEFICIENCIES DEPONIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			3737 BRY				
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 945 Continued From page 2 decline of nutrition and hydration status for 1 of 3 residents (R1) reviewed for nutrition and hydration. This resulted in actual harm when R1 was admitted to the hospital with sepsis, pneumonia and dehydration that required intravenous hydration and nutrition therapy. Findings include: R1 was admitted to the facility on 12/4/20. R1's pre-admission history and physical progress notes indicated R1 had not been eating, drinking or taking medications. R1 had received palliative care and hospice evaluations but R1's family declined hospice evaluations but R1's family declined hospice with eating. The MDS indicated no signs or symptoms of possible swallowing disorder. R1's diagnosis included non-Alzheimer's dementia, metabolic encephalopathy (a problem in the brain caused by chemical imbalance in the blood) and renal insufficiency (a condition in which the kidneys lose ability to remove waste).	WALKER	R METHODIST HEALT	H CENTER MINNEAF	POLIS, MN 5	5409		
decline of nutrition and hydration status for 1 of 3 residents (R1) reviewed for nutrition and hydration. This resulted in actual harm when R1 was admitted to the hospital with sepsis, pneumonia and dehydration that required intravenous hydration and nutrition therapy. Findings include: R1 was admitted to the facility on 12/4/20. R1's pre-admission history and physical progress notes indicated R1 had not been eating, drinking or taking medications. R1 had received palliative care and hospice evaluations but R1's family declined hospice care. R1's admission Minimum Data Set (MDS) dated, 12/10/20, identified R1 with severe cognitive impairment and required extensive assistance with eating. The MDS indicated no signs or symptoms of possible swallowing disorder. R1's diagnosis included non-Alzheimer's dementia, metabolic encephalopathy (a problem in the brain caused by chemical imbalance in the blood) and renal insufficiency (a condition in which the kidneys lose ability to remove waste).	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE
identified R1 required a regular diet with regular textures and thin liquids. The assessment further identified R1 was completely dependent on staff to eat and had no difficulties with chewing or swallowing. The nutritional assessment was completed by the dietary technician (DT) who reviewed progress notes and spoke with R1's family. The nutritional assessment did not include any meal or intake observations of R1 by the DT or registered dietician (RD). R1's care plan initiated 12/4/20, identified R1 had	2 945	decline of nutrition a residents (R1) revie hydration. This result was admitted to the pneumonia and derintravenous hydration. Findings include: R1 was admitted to pre-admission histor notes indicated R1 or taking medication care and hospice endeclined hospice cannot be indicated R1 or taking medication care and hospice of declined hospice of declined hospice cannot be indicated R1 or taking. The ME symptoms of possible diagnosis included metabolic encephal caused by chemical renal insufficiency (kidneys lose ability). R1's nutritional associated R1 require textures and thin liquidentified R1 was contour to eat and had not diswallowing. The nutrition any meal or intake or registered dieticism.	and hydration status for 1 of 3 ewed for nutrition and alted in actual harm when R1 hospital with sepsis, hydration that required on and nutrition therapy. The facility on 12/4/20. R1's bry and physical progress had not been eating, drinking hs. R1 had received palliative valuations but R1's family are. Imum Data Set (MDS) dated, R1 with severe cognitive uired extensive assistance DS indicated no signs or ble swallowing disorder. R1's non-Alzheimer's dementia, opathy (a problem in the brain I imbalance in the blood) and a condition in which the to remove waste). Dessment dated 12/7/20, and a regular diet with regular uids. The assessment further completely dependent on staff ifficulties with chewing or attritional assessment was letary technician (DT) who notes and spoke with R1's hal assessment did not include observations of R1 by the DT an (RD).	2 945			

Minnesota Department of Health

STATE FORM 6899 HWDV11 If continuation sheet 3 of 11

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00276	B. WING		12/2	28/ 2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 945	a nutritional probler problem and instruct and report any sign (difficulty swallowing further instructed reand make diet charneeded. R1's physician orde "SLP: Eval and Tx [to evaluate and treat" to evaluate and treat" Provide 120 cc [cunutrition supplement Document [percent dietician] if pt. refus R1's progress notes indicated R1 did no because she "can't throws away food other at times. Cand drank 60 cc of spoke with [R1's far intakeRefusing to stated patient likes few bites at a time as a while later. NP [nuupdated on status. physician order for cup (a nutritional suin flavor and texture in the status of	m or potential nutritional cted staff to monitor, document is or symptoms of dysphagia g) or refusal to eat. Care plantegistered dietician to evaluate ingerecommendations as a redated 12/4/20, indicated, ispeech-language-pathologist at]." For dated 12/7/20, indicated, bic centimeters] HNS [house int] TID [three times a day]. Intake. Notify RD [registered interes are gittered interes and interes and interes and interes are gittered interes and interest and in	2 945			
		s dated 12/8/20, at 2:00 p.m.				

Minnesota Department of Health

STATE FORM 6899 HWDV11 If continuation sheet 4 of 11

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
					_ c	
		00276	B. WING		12/2	8/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU			
		MINNEAP	OLIS, MN 5	5409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 945	Continued From pa	ige 4	2 945			
	meals."					
		s dated 12/9/20, at 1:17 p.m. only taking a few bites at				
	indicated, "She has to open mouth, clin pushing away staff	dated 12/10/20, at 9:12 p.m. s not been eating well, unable ched her teeth during meals or hand when been [sic] fed. behavior with med intake."				
	R1's progress note indicated, "Pt has p	dated 12/11/20, at 1:40 p.m. poor diet intake."				
	indicated, "She refu meals-unable to op	dated 12/12/20, at 8:43 p.m. used both meds and ben mouth, clinched her teeth shing away staff hand when				
	9:47 a.m. indicated	late entry dated 12/14/20, at nurse practitioner was t not eating and only taking				
	indicated "writer we and she noted that that pt was not resp was not opening he arms and body will breathing RR [resp pressure] 103/63 P RA [room air]. Oxyg initiated and pt's ox NC [nasal cannula] was present in the and she stated," I v	dated 12/14/20, at 8:20 p.m. ent to take pt her medication pt was unable to swallow and conding to verbal stimuli. Pt er eyes and periodically pt's shake. Pt had shallow iratory rate] 28 B/P [blood [pulse] 89 Oxygen 62-75% on gen administration was eygen came up to 95% on 2L. Writer updated [F-A] who room about her mom's status want to give her a fighting that she is not ready for				

Minnesota Department of Health

STATE FORM 6899 HWDV11 If continuation sheet 5 of 11

PRINTED: 01/20/2021 FORM APPROVED

Minnesota Department of Health

AND DIAN OF CORRECTION TO TRENTIFICATION NUMBERS	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
00276	B. WING	C — 12/28/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDI	RESS, CITY, STATE, ZIP CODE	·
WAI KER METHODIST HEAI TH CENTER	NT AVENUE SOUTH DLIS, MN 55409	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCE	AN OF CORRECTION (X5) ZE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY) (X5) COMPLETE DATE
comfort cares." [F-A] was also on the phone with [F-B] who also indicated that they want immediate interventions and that they wanted their mother to be seen physically by the doctor. Writer paged on calland was updated of the pt's status and pt's family wishes and she stated to send pt to the ER at 1857 [6:57 p.m.] Emergency services were called Pt left the facility at 1923 [7:23 p.m.] on a stretcher with the EMT [for the hospital]." R1's Nutrition Amount Eaten record for 12/5/20 through 12/13/20, indicated R1 ate 0-25% of meal 17 times, 26-50% of meal 1 time, 51-75% of meal one time and refused four times. R1's Nutrition Amount Drank record indicated R1 had no fluid intake on two days and 120 cc or less on four days. The remaining three days, R1's record indicated R1 consumed 720 cc, 300 cc and 150 cc. When interviewed on 12/23/20, at 1:36 p.m. family member (F)-A stated she saw R1 in a video chat on 12/9/20, and described R1 had "a very dry mouth and lips sticking together." F-A stated she spoke with an unidentified staff member at the facility who encouraged her to take the facility provided essential caregiver class so that F-A could visit R1. F-A took the class on 12/12/20. On 12/14/20, F-A was informed of R1's poor intake and was encouraged to visit R1 for dinner on that day to see if F-A could get R1 to eat. F-A stated she arrived at the facility at about 5:15 p.m. and attempted to assist R1 with the dinner meal. F-A stated the food and beverage fell out of R1's mouth. F-A never saw R1 swallow anything that visit. F-A described R1 as "totally unresponsive" and with a "very dry mouth." F-A stated when registered nurse (RN)-A came in and saw R1, RN-A seemed surprised at R1's	2 945	

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.		,	C
		00276		B. WING			28/2020
NAME OF PF	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	METHODIST HEALT	H CENTER		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	Continued From partime she worked with obtained a set of vith (blood oxygen lever) placed oxygen on French R1 to the hos stated paramedics have made it through the hospital when see condition was becared. F-A further stated the members had called throughout R1's ad not told R1 was not see R1 in person 12/14/20. RD stated progress notes to cassessment. RD stated progress notes to casses notes to ca	ith her on 12/11/2 tal signs and R1 I) were 65%. RN R1. A decision we pital and 911 was told her R1 problems to the hat either she or detection of the facility two mission for updates and the facility two mission for updates are detected to contact Fuccessful. In 12/24/20, at 9 (RD) stated she must hat eating or drinking able so the facility two mission for updates are detected to the facility two mission for updates are detected to contact Fuccessful. In 12/24/20, at 9 (RD) stated she must hat hat R1 had not not being able so to the facility of the facility would expect to m staff as soon the facility of the facility would expect to m staff as soon the facility of the facility would expect to m staff as soon the facility of the facility	's O2 sats N-A then as made to s called. F-A pably would not d did not go to ed R1's eat or drink. other family times a day ates and were ng. RN-A for 2:13 a.m. was unable he facility on ved R1's nission ave missed taken swallow. RD d not take the nat "in a be notified of as they were ion did not 45 a.m. RN-B c and would came [to work on't [sic] eat o give her mouth and " RN-B stated	2 945			

Minnesota Department of Health

STATE FORM 6899 HWDV11 If continuation sheet 7 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00276	B. WING			8/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 945	not eating. RN-B st because she thoug aware. RN-B stated document the resid health record (EHR supposed to asses resident's intake. When interviewed of RN-C stated that sp and they typically so of admission. "Ever and nutrition asses reasonable amount upon admission R1 refused food. RN-C therapist (ST) and someone did not earlier for speech the treatment dated 12 why R1 did not reconfirmed R1 indicated R1 did not swallow. RN-C state complete an in-persection and would resident was unable stated the nurse sh nurse practitioner (were identified. RN admitted to the host intravenous fluid ac Creatinine level. RN Creatinine indicates.	th therapy when a resident was ated she did not notify anyone ht everyone was already dithe nursing assistants (NAs) lent's intake into the electronic did and the nurses were is the resident and review the state of the resident and review the state of the resident within 24 hours in through Covid all therapy sments were being done in a state of time." RN-C stated that had difficulty to swallow and continued further stated the speech RD should be notified when at. RN-C verified R1 had an erapy evaluation and leive that evaluation. RN-C R1's nutrition assessment with the contact the family if the eto communicate. RN-C would notify dietary and the NP) when intake concerns -C further stated R1 was epital on 12/14/20, for diministration and an elevated N-C further stated, "Elevated"	2 945			
	When interviewed	on 12/28/20, at 11:05 a.m. ST				

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STATE FORM 6899 HWDV11 If continuation sheet 8 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00276	B. WING			8/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 945	why she was not no order. ST stated that clinical coordinators for speech or swall she always enters a when she saw a remo progress note for reviewing R1's EHF definitely seen R1 a indicated concerns. Attempt to contact unsuccessful and the unavailable for inte. When interviewed dietary technician (complete the initial within the first three. "I usually go and senot going to be able the family." DT coudid talk to R1's fam completion of the in 12/7/20. "I just wen to the family. I look see the 'can't swall. DT stated she woultherapy had she se appetite into considerated her on the I was supposed to secomplete admission five days of the initi have been 12/12/20 attempt to visit [the communicate with the communicat	see R1 and could not explain of officed of the speech evaluation at Monday through Friday, the sonotify ST of any new orders ow therapy. ST further stated a progress note into the EHR sident and verified there was om her in R1's chart. While R, ST stated she would have as the progress notes when R1 swallowed. The clinical coordinators were herefore, they were rview. The clinical coordinators were herefore, they were rview.	2 945			

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00276	B. WING		12/2	8/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU			
	OLIMAN AND DV OTA		OLIS, MN 5			4.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 945	Continued From pa	ige 9	2 945			
	assistant director of RD or DT would do all residents within admission. ADON size done in person in communicate, other family interviews. The supposed to run and notes for the previous noted from the report discussed in the day which dietary was a stated any swallow been discussed in the team) meetings as	f nursing (ADON) stated the a nutritional assessment on 3 business days from stated the assessment should if resident was able to erwise they rely on staff and The clinical managers were report and review all progress ous 24 hours. Any concerns ort or notes should have been ally (M-F) clinical meeting in always present. ADON further ing concerns should have the unit IDT (interdisciplinary well. ADON verified R1's nent dated 12/7/20, did not				
	indicated R1's adm severe sepsis, pne- kidney injury. R1's	ssion note dated 12/14/20, ission diagnoses included umonia, dehydration and acute Creatinine was 3.25 mg/dl illiter) (normal Creatinine range mg/dl).				
	note dated 12/23/30 intake was "not only cognitive status but function alone - pt's do not allow her to trigger any function evaluation dated 12	by hospital inpatient progress 0 indicated, R1's lack of oral y related to refusals/her t also related to the swallow s physical oral motor abilities manipulate food or liquid or all swallow." A clinical swallow 2/17/20, indicated speech w R1 daily and attempt oral e.				
	revised 12/31/18, ic nutritional assessm	lutrition Assessments last dentified a comprehensive nent was to be used to nd hydration risks. Within				

Minnesota Department of Health

STATE FORM 6899 HWDV11 If continuation sheet 10 of 11

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLI	
	<u> </u>
	8/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
WALKER METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
three business days of admission, an RD or DT must complete an Initial Nutrition Interview/Screen. The RD should complete a Nutrition Assessment upon admission using "direct observation of and communication with the resident, other potential resources, licensed and non-licensed staff [all shifts] physician, family members, or external consultants as appropriate and review of the clinical record." The undated facility process Scheduling Steps instructed the clinical record." The undated facility process Scheduling Steps instructed the clinical coordination staff to check the EHR for therapy orders and outlined a step by step process on how to search for therapy orders in the EHR. The process further instructed staff to assign a resident to a therapist's caseload and then print the individual therapists' schedules with key points such as evaluations highlighted. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods and fluids given, offered, or consumed by residents reflect the nutritional needs to prevent nutritional decline and dehydration. The facility could ensure swallow evaluations, when ordered, as completed per physician order. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions. The administrator, registered dietician, or designee could perform audist for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI). The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	

6899

Minnesota Department of Health STATE FORM

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

	0303), Wasiii.	ngton, D.C. 2	0503.				
Number	Pro	vider/Supplie	er Name				
	WAI	KER METHODIST	HEALTH CTR				
ct all that a	pply):	B Dumping In C Federal Mo	vestigation nitoring	F Inspec G Valida	tion of Car tion	re J Sano K Stat	ction/Hearing ce License
Lect all that	apply):	A Routine/St B Extended S C Partial Ex	andard (all urvey (HHA o tended Surve	providers/s r long term	uppliers)		N
						,	
First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)		Off-Site Report Preparation Hours (I)
12-23-2020	12-23-2020	2.00	0.00	7.00	0.00	0.00	4.00
	Number ct all that a	Number Pro WAI ct all that apply): Lect all that apply): kload information for each First Last Date Date Arrived Departed (B) (C)	Number Provider/Supplies WALKER METHODIST Ct all that apply): A Complaint B Dumping In C Federal Mo D Follow-up Lect all that apply): A Routine/St B Extended S C Partial Ex D Other Surve SURVEY TEAM A kload information for each surveyor. First Last Pre-Survey Date Date Arrived Departed (B) (C) (D)	Number Provider/Supplier Name WALKER METHODIST HEALTH CTR ct all that apply): A Complaint Investigation C Federal Monitoring D Follow-up Visit Lect all that apply): A Routine/Standard (all B Extended Survey (HHA o C Partial Extended Survey D Other Survey SURVEY TEAM AND WORKLOAD: kload information for each surveyor. Use the sur First Last Pre-Survey On-Site Date Date Preparation Hours Arrived Departed Hours 12am-8am (B) (C) (D) (E)	Number Provider/Supplier Name WALKER METHODIST HEALTH CTR A Complaint Investigation E Initia B Dumping Investigation F Inspec C Federal Monitoring G Valida D Follow-up Visit H Life s Lect all that apply): A Routine/Standard (all providers/s B Extended Survey (HHA or long term C Partial Extended Survey (HHA) D Other Survey SURVEY TEAM AND WORKLOAD DATA kload information for each surveyor. Use the surveyor's information for each surveyor. Use the surveyor's information for each surveyor. Hours Date Date Date Date Preparation Arrived Departed Hours (B) (C) (D) (E) (F)	Number Provider/Supplier Name WALKER METHODIST HEALTH CTR Ct all that apply): A Complaint Investigation E Initial Certifica B Dumping Investigation F Inspection of Car C Federal Monitoring G Validation D Follow-up Visit H Life safety Code Lect all that apply): A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facil C Partial Extended Survey (HHA) D Other Survey SURVEY TEAM AND WORKLOAD DATA kload information for each surveyor. Use the surveyor's information nu First Last Pre-Survey On-Site On-Site On-Site Date Arrived Departed Hours Hours Hours Arrived Departed Hours 12am-8am 8am-6pm 6pm-12am (B) (C) (D) (E) (F) (G)	Number Provider/Supplier Name WALKER METHODIST HEALTH CTR Ct all that apply): A Complaint Investigation E Initial Certification I Rec B Dumping Investigation F Inspection of Care J Sand C Federal Monitoring G Validation K Stat D Follow-up Visit H Life safety Code L Chow Lect all that apply): A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA) D Other Survey SURVEY TEAM AND WORKLOAD DATA kload information for each surveyor. Use the surveyor's information number. First Last Pre-Survey On-Site On-Site On-Site Travel (B) Date Preparation Hours Hours Hours Hours Arrived Departed Hours 12am-8am 8am-6pm 6pm-12am (H) (C) (D) (E) (F) (G) (H)

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier	Number	Pro	vider/Supplie	r Name				
245055			KER METHODIST					
ype of Survey (sele	ct all that a	pply):	A Complaint B Dumping In C Federal Mo D Follow-up	vestigation nitoring	F Inspec G Valida	tion of Car	e J Sand	certification ction/Hearing ce License
xtent of Survey (Se	lect all that	apply):	A Routine/St B Extended S C Partial Ex	andard (all urvey (HHA c	providers/s r long term	uppliers)		•
			D Other Surv	ey				
			SURVEY TEAM A	ND WORKLOAD	DATA			
lease enter the wor Surveyor Id Number (A)	kload informa First Date Arrived (B)	Last Date Departed (C)	h surveyor. Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)		ff-Site Report Preparation Hours (I)
Team Leader 1. 42584	12-23-2020	12-23-2020	0.50	0.00	2.00	0.00	0.50	0.00
2.								
3.								
4.								
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6.								
7.								
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10.								
		•						
otal Supervisory Re	view Hours							1.25

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245055			Provider/Supplier Name WALKER METHODIST HEALTH CTR							
Type of Survey (select all that appl			B Dumping In C Federal Mo D Follow-up	vestigation nitoring Visit	G Validation K Sta			anction/Hearing tate License		
A		A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA) D Other Survey								
			SURVEY TEAM A	ND WORKLOAD	DATA					
Please enter the work Surveyor Id Number (A)	kload informa First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	veyor's info On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)		Off-Site Report Preparation Hours (I)		
Team Leader 1. 42584	01-25-2021	01-25-2021	0.75	0.00	1.50	0.00	0.00	0.00		
2.										
3.										
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9.										
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1		•								
Total Supervisory Rev	view Hours							0.00		
Total Clerical/Data B	Entry Hours							2		

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number Pr		Provider/Supplier Name							
245055		WAI	KER METHODIST	HEALTH CTR					
A K A K Attent of Survey (Select all that apple)			A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit		E Initial Certification F Inspection of Care G Validation H Life safety Code		e J Sand K Stat	on I Recertification J Sanction/Hearing K State License L Chow	
A A			A Routine/St B Extended S C Partial Ex D Other Surv	urvey (HHA o	r long term		ity)		
		1	SURVEY TEAM AI	ND WORKLOAD	DATA				
ease enter the wor	kload informa	tion for eac	h surveyor.	Use the sur	veyor's info	ormation nu	mber.	1	
urveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (H)	off-Site Report Preparation Hours (I)	
. 42582	01-25-2021	01-25-2021	0.50	0.00	1.50	0.00	0.00	0.50	
Team Leader · 42584	12-23-2020	12-28-2020	0.50	0.00	16.00	0.00	0.50	9.75	
•									
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0.									
		1	1			-	1	1	
al Supervisory Rev	<i>j</i> iew Hours							1.75	