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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: I69L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00276

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245055**
2.STATE VENDOR OR MEDICAID NO.
(L2) **202742900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER METHODIST HEALTH CENTER**
(L4) **3737 BRYANT AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

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 **06/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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)
02/28

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

12.Total Facility Beds **330** (L18)
13.Total Certified Beds **330** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	308	22		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NEII 06/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/09/2016 (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
01/01/1967
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/13/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5055

On June 22, 2016, a Post Certification Revisit (PCR) was completed by the Department of Health including a follow up to verify compliance related to a complaint investigation number H5055194 found substantiated at F312, and on June 17, 2016, the Minnesota Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the April 29, 2016 recertification survey, effective June 8, 2016. Refer to the CMS 2567b for both health and life safety code.

Effective June 8, 2016, the facility is certified for 308 skilled nursing facility beds and 22 nursing facility I beds..

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245055

August 9, 2016

Ms. Jaclyn Jezierski, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

Dear Ms. Jezierski:

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 June 8, 2016 the above facility is certified for:

308	Skilled Nursing Facility/Nursing Facility Beds
22	Nursing Facility I Beds

Your facility's Medicare approved area consists of all 308 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2016

Ms. Jaclyn Jezierski, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

RE: Project Number S5055026, H5055194

Dear Ms. Jezierski:

On May 13, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 29, 2016 that included an investigation of complaint number H5055194. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 17, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 29, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 29, 2016, effective June 8, 2016 and therefore remedies outlined in our letter to you dated May 13, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245055 Y1	A. Building B. Wing Y2	6/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0246	Correction	ID Prefix F0254	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.15(e)(1)	Completed	Reg. # 483.15(h)(3)	Completed
LSC	06/08/2016	LSC	06/08/2016	LSC	06/08/2016
ID Prefix F0282	Correction	ID Prefix F0312	Correction	ID Prefix F0329	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(l)	Completed
LSC	06/08/2016	LSC	06/08/2016	LSC	06/08/2016
ID Prefix F0371	Correction	ID Prefix F0428	Correction	ID Prefix F0431	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	06/08/2016	LSC	06/08/2016	LSC	06/08/2016
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	06/08/2016	LSC	06/08/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	06/28/2016	32976	06/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/29/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245055 Y1	A. Building 01 - BUILDING 01 B. Wing Y2	6/17/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0029	06/08/2016	LSC K0046	06/08/2016	LSC K0054	06/08/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0066	06/08/2016	LSC K0076	06/08/2016	LSC K0143	06/08/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0144	06/08/2016	LSC K0147	06/08/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	06/28/2016	37009	06/17/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/28/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2016

Ms. Jaclyn Jezierski, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

Re: Reinspection Results - Project Number S5055026, H5055194

Dear Ms. Jezierski:

On June 17, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 29, 2016, that included an investigation of complaint number H5055194. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00276 Y1	A. Building B. Wing Y2	6/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20920	Correction	ID Prefix 21015	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0525 Subp. 6 B	Completed	Reg. # MN Rule 4658.0610 Subp. 7	Completed
LSC	06/08/2016	LSC	06/08/2016	LSC	06/08/2016
ID Prefix 21375	Correction	ID Prefix 21426	Correction	ID Prefix 21530	Correction
Reg. # MN Rule 4658.0800 Subp. 1	Completed	Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1310 A.B.C	Completed
LSC	06/08/2016	LSC	06/22/2016	LSC	06/08/2016
ID Prefix 21540	Correction	ID Prefix 21670	Correction	ID Prefix 21730	Correction
Reg. # MN Rule 4658.1315 Subp. 2	Completed	Reg. # MN Rule 4658.1405 A.B.C.D.	Completed	Reg. # MN Rule 4658.1415 Subp. 11	Completed
LSC	06/08/2016	LSC	06/08/2016	LSC	06/22/2016
ID Prefix 21800	Correction	ID Prefix 21810	Correction	ID Prefix	Correction
Reg. # MN St. Statute144.651 Subd. 4	Completed	Reg. # MN St. Statute 144.651 Subd. 6	Completed	Reg. #	Completed
LSC	06/08/2016	LSC	06/08/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	06/28/2016	32976	06/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 4/29/2016

☐ 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: I69L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00276

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245055**
2.STATE VENDOR OR MEDICAID NO.
(L2) **202742900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER METHODIST HEALTH CENTER**
(L4) **3737 BRYANT AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

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 **04/29/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (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)
02/28

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

12.Total Facility Beds **330** (L18)
13.Total Certified Beds **330** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	308	22		
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 06/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/10/2016 (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
01/01/1967
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5055

On April 29, 2016 a recertificatoin survye was completed at Walker Methodist Health Center to verifiy if the facility maintain compliance with Federal participation regulations. Deficiencies were found at a Scope and Severity of F. In addition at the time of the recertification survey, complaint investigatoins were conducted and the following are the results:

-Inivestigatoin of complaint numbers: H5055191, H5055193, H5055187 and H5055192 were conducted and found to be unsubstantiated
- investigation of complaint H5055194 was conducted and found to be substantiated at a D for F312.

The facility is given an opportunity to correct before remedies would be imposed. Refer to the CMS 2567 for both health and life safety code along with the facilty's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 13, 2016

Ms.. Brooke Peoples, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

RE: Project Number S5055026, H5055187, H5055191, H5055192, H5055193, H5055194

Dear Ms.. Peoples:

On April 29, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the April 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5055187, H5055191, H5055192, H5055193, H5055194.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the April 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5055187, H5055191, H5055192, H5055193 and found them to be unsubstantiated. Investigation of complaint number H5055194 was found to be substantiated at F312.

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

Remedies - 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;

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

Informal Dispute Resolution - 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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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 June 8, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 8, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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).

Failure to submit an acceptable ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 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.

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 July 29, 2016 (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 October 29, 2016 (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
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: 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 electronic 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

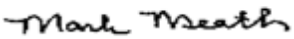
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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. In addition to the recertification survey, complaints were investigated. An investigation of complaint H5055194 was substantiated at a D for F312. Additionally, complaints H5055191, H5055193, H5055187, H5055192 were investigated and were unsubstantiated.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in	F 156		6/8/16

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

Electronically Signed | 05/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending	F 156		

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F 156	Continued From page 2 down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice in a timely manner prior to the termination of Medicare skilled services for 2 of 3 residents (R247, R493) reviewed for liability notice and beneficiary appeal rights. Findings include:	F 156	"R247 and R493 have since discharged from the facility. "All residents will be provided with a proper liability and appeal rights notice in a timely manner prior to termination of Medicare skilled services. "The Medicare RNs have been educated on the requirement to provide proper	

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F 156	Continued From page 3 During review of facility liability notice and beneficiary appeal rights for R247 and R493 on 4/27/16, the following was noted: R247's medical record was reviewed for the Notice of Medicare Provider Non-Coverage forms (NMPNC) on 4/27/16. The medical lacked the forms NMPNC that were to be signed by recipients at least 48 hours prior to the end of their Medicare coverage in the facility. However the social service discharge and recapitulation summary dated 12/6/15 read, "resident received PT, OT and speech therapies along with skilled nursing services. Resident to discharge home with home PT and OT therapies." On 4/27/16, at 7:33 a.m. registered nurse (RN)-A stated, the Skilled Nursing Facility Advance Beneficiary Notice and the Notice of Medicare Non-Coverage should be given at least two days before covered services would end. RN-A stated R247 was discharge prior to the 90 days and voluntarily wanted to go home on day 89 and R247 was on and off therapy. In addition, RN-A mentioned, "I did not give the liability and appeal rights notice because of that. Otherwise, I would have given the 48 hours notices." R493's medical record review for the NMPNC on 4/27/16, revealed the record lacked the forms that were to be signed by recipients at least 48 hours prior to the end of their Medicare coverage in the facility. However the social service discharge and recapitulation summary dated 12/3/15, read "Date discharge order received: 12/3/15. Community resources/addition information: Resident to d/c [discharge] to Augustina ALF [assisted living facility] with support."	F 156	liability and appeal rights notice in a timely manner prior to termination of Medicare. "Monitoring to ensure compliance will be conducted by the Administrator or designee through the monthly Medicare Audits. "The facility QAPI committee will review the status of the Medicare audits for further recommendations.	

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F 156	Continued From page 4 On 4/27/16, at 7:37 a.m. RN-A stated the Skilled Nursing Facility Advance Beneficiary Notice and the Notice of Medicare Non-Coverage should be given at least two days before covered services would end. R493 was admitted to the facility for 17 days and discharged choosing to go to an assisted living. Furthermore, RN-A declared, "I did not give the liability and appeal rights notice because of that. Otherwise, I would have given the notice within the 48 hours window." On 4/27/16 at 11:18 a.m. RN-A confirmed, the medical record lacked Skilled Nursing Facility Advance Beneficiary Notice and the Notice of Medicare Non-Coverage for R247 and R493 and stated the resident would have remained skilled until a denial letter was issued. RN-A further stated her expectation was a letter was to be issued to the resident within 48 hours of anticipating no daily skilled services. On 4/27/16 at 11:26 a.m. the rehabilitation (rehab) director verified, the rehab medical records for for R247 and R493 lacked requests to be discharged. The director added, "We do a discharge planning meeting with resident and family as needed and give a 48 hour notice to the Medicare nurse and the rest of the IDT [interdisciplinary team] prior to discharge. In absence of formal meetings, resident and family are notified by the therapist." A facility policy and procedure titled NOTICE OF MEDICARE/MEDICAID BENEFITS dated 2014, read, "Individuals receiving Medicare benefits are re-evaluated on a regular basis by the facility's Medicare coordinator to determine continued coverage based on the daily skilled need. If and	F 156		

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F 156	Continued From page 5 when it is determined the resident no longer requires a Medicare skilled service, the facility will notify the resident or responsible party at least 48 hours prior to the change in payer source. If the resident or financially responsible party does not agree with this decision, you will be given the option at that time to request a demand bill. This process will be explained in full at the time of the denial of Medicare benefits."	F 156		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure call lights were placed within reach for 1 of 1 resident (R335). Findings include: R335 was observed on 4/25/16, at 3:22 p.m. The resident was seated in a wheelchair. One side of the bed was pushed up against the wall. R335's call light was out of her reach and hung down from the call light box approximately 18 inches above the bed. R335 reported, "The call light is never in reach. It's always in that position along the wall where I can't reach it." R335 explained if she needed help she would have to yell for staff	F 246	"R353□s call light has been placed within reach. "All residents call lights will be placed within reach. "Facility staff have been educated on the requirement to place a resident□s call light within reach. "Monitoring to ensure compliance will be conducted by the DON or designee through weekly call light placement audits. "The facility QAPI committee will review the status of the Medicare audits for further recommendations.	6/8/16

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F 246	Continued From page 6 to come. On 4/26/16, at 9:59 a.m. R335's call light again was out of her reach as it was clipped to the call light box where the bed was pushed up against the wall. R335 said, "I guess I would have to wait until someone comes along [to get help]." R335 then requested "please clip the call light to the bed" so she could reach it. At 4:15 p.m. R335's family member (FM)-A was visiting the resident and stated, "My mother's call light is rarely in place for her to use." On 4/27/16, at 9:40 a.m. R335's call light was observed out of her reach. R335 was seated in her wheelchair. The call light was lying on the floor next to the bed. When asked if she was able to reach the call light she replied, "No. It's on the floor and I'm in my wheelchair." R335's care plan dated 1/21/14, indicated R335 had macular degeneration causing blindness in one eye, and the resident was at risk for falls. Staff was directed to ensure R335's call light was within her reach at all times, inform the resident where to find the light, and to encourage the resident to use the light to call for help. The care plan noted the resident required staff assistance with transfers, bed mobility, and ambulation. On 4/27/16, at 9:50 a.m. nursing assistant (NA)-C reported she was assigned to care for R335 for the day, and was familiar with the her care requirements. NA-C verified R335's call light was noted on the floor and she would not have been able to reach it should she need to summon help. On 4/27/16, at 10:07 a.m. the assistant director of nursing (ADON) explained she expected all	F 246		

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F 246	Continued From page 7 residents would have their call lights within reach, even if the resident was unable to utilize the light. In addition, the ADON explained staff should ensure call lights were within the residents' reach at all times. A policy on call light was requested, but was not provided.	F 246		
F 254 SS=E	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to ensure bed linens were clean and/or in good repair for 3 of 3 residents observed (R69, R425, R439) and to ensure the clean linens stored for use were in good repair. This had the potential to affect all residents who utilized the linens. Findings include: On 4/27/16, at 1:15 p.m. R69 was siting in the dining room after lunch with her head resting on the table. A nursing assistant (NA)-B stated she was going to to bring R69 to her room to lie down for the afternoon. NA-B stated R69 required the assistance of two staff with the use of a hoyer lift (a mechanical full body lift). R69 was placed in bed and NA-B covered her with a blanket. There was a large brown circular stain approximately 6 inches round on top of the bed blanket. At 1:39 p.m. registered nurse (RN)-G stated R69 had the	F 254	"R69, R425, and R439 have all been provided with clean bed linens that are in good repair. "All residents have been provided with clean bed linens that are in good repair. "The facility linen policy has been updated to reflect the facility procedure for storing linens and discarding linens. Laundry staff have been educated on the linen policy to ensure only clean linens in good repair are delivered to the storage rooms. Licensed nursing staff have been educated on the linen policy to ensure only clean linens in good repair are provided to residents. "Monitoring to ensure compliance will be conducted by the Administrator or designee through weekly audits of the clean linen storage rooms and random audits of resident□s beds. "The facility QAPI committee will review	6/8/16

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F 254	Continued From page 8 behavior of digging at her buttocks after she has had a bowel movement (BM). The ADON stated staff was aware of R69's behavior of digging and smearing feces. During the environmental tour on 4/28/16, at 9:05 a.m. the following staff was present, maintenance supervisor (MS), director of nursing (DON) and housekeeper/laundry supervisor (HS/LS). The following was noted: 1. R69's bed was observed to be made, the sheets tucked in, the top blanket was pulled up and R69's pillow was neatly placed at the head of the bed. However during the tour, R69's top bed blanket still contained the same stained observed on 4/27/16. When the sheets were pulled back the fitted sheet was visually worn and stained. R69's pillow was turned over and a brown substance was noted on the back side of her pillow case. 2. R425's fitted sheet was very thin and had visible wear marks. 3. R439's fitted sheet was so thin the mattress could be seen though it when held up. 4. 7 Gamble's clean linen closet had one fitted sheet that was worn with a hole in it and two fitted sheets that had dried on sticky food. 5. 4 Rain's clean linen closet contained fitted sheets that were worn and had holes. The three staff present during the tour verified the linens were not in good condition and should not have been placed on resident's beds or in the clean linen rooms. All staff stated their	F 254	the status of the linen audits for further recommendations.	

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F 254	Continued From page 9 expectations were if staff observed dirty bed linens or in bad condition they should be replaced and/or thrown away. The HS/LS verified the clean linen closets on 4 Rains and 7 Gamble had sheets that were not in good condition. HS/LS declined to look through other clean linen closets in the facility and stated there was a system problem with nursing and laundry staff. On 4/29/16, at 8:26 a.m. the laundry room was toured with the HS/LS. Laundry aide (LA)-A was folding clean linen and explained if any laundry items were thin or had holes in them they were thrown away and "we never bring up dirty linens." The HS/LS went to a laundry cart ready for the floor. Fitted sheets were pulled from the clean cart still warm from the dryer. The HS/LS sorted through the sheets one by one. As he got to a sheet that was too thin, had a hole or a stain he tossed it to LA-A and informed LA-A they were not to be used. Within a short period of time, more than 15 fitted sheets were thrown away. The HS/LS explained they had recently changed vendors and the sheets that are worn were from the old vender. He verified the sheets were thin, not in good condition and needed to be replaced. The facility's policy titled "Linens-Clean" dated 7/17/20, indicated "clean laundry/bedding is to be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen." Although requested, no policy related to linen replacement was provided.	F 254		
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	F 282		6/8/16

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	245055	A. BUILDING _____ B. WING _____	04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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F 282	Continued From page 10 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plans were followed for 1 of 1 residents (R335) reviewed for accommodation of needs and 3 of 5 residents (R69, R336, R18) reviewed for activities of daily living (ADL's). Findings include: R335's care plan dated 1/21/14, indicated R335 had macular degeneration, blind in left eye and was at risk for falls. Intervention for staff to provide R335 included be sure call light is within reach at all times when in room, encourage to use and tell resident where call light was placed. R335 required the assistance of one staff for transfers, bed mobility and ambulation. On 4/25/16, at 3:22 p.m. R335 was sitting in her wheelchair (w/c) alone in her room watching the television. The left side of R335 bed was pushed against the wall. R335's call light was out of reach, hanging down from the call light system located on the wall approximately 18 inches above R335 bed. R335 said "The call light is never in reach it's always in that position along the wall where I can't reach it." On 4/26/16 at 9:59 a.m. R335 call light again was observed to be out of reach. If she needed help, R335 said " I guess I would have to wait until some comes along." Later that day at 4:15 p.m. family member (FM)-A said, "My mother's call	F 282	"R335, R69, R336 and R18□s care plans have been reviewed and updated as necessary. "The care plans of all residents who are unable to carry out activities of daily living have been reviewed and updated as necessary. "Licensed nursing staff have been educated on the requirement to review and update the care plan according to resident needs. "Monitoring to ensure compliance will be conducted by the DON or designee through weekly audits of resident care plans. "The facility QAPI committee will review the status of the care plan audits for further recommendations.	

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F 282	Continued From page 11	F 282		

light was rarely in place for her to use."

On 4/27/16, at 9:40 a.m. R335 call light once again was not in reach. R335 was sitting in her w/c alone in her room. The call light was lying on the floor next to her bed. R335 was asked if she could reach her call light R335 replied "No, it's on the floor and I'm in my w/c."

During an interview on 4/27/16, at 9:50 a.m. nursing assistance (NA)-C stated she was the person taking care R335 for the day and was familiar with her cares. NA-C verified R335's call light was noted on the floor and R335 would not have been able to reach it if she needed help.

During an interview on 4/27/16, at 10:07 a.m. assistant director of nursing (ADON) explained she expected all resident to have their call light within reach even if that resident can't use it.

R69's care plan dated 3/25/14, identified interventions from staff was to assist with 1 for ADL's and to thoroughly wash hands and under nails due to often digging and smearing Bowel Movement (BM).

On 4/27/16, at 7:33 a.m. R69 was observed sitting eating her breakfast in the dining room. All of R69's fingernails and cuticles were dirty, imbedded with a dry dark black/brown color substance. Later that day at 1:15 p.m. R69 was siting in the dining room after lunch with her head resting on the table her nails remained dirty. Nursing assistant (NA)-B stated she was going to to bring R69 back to her room to lie down for the afternoon. NA-B placed her in bed and covered her with a blanket. No other cares was provided to R69.

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On 4/27/16, at 1:39 p.m. registered nurse (RN)-G stated R69 got her nails done almost everyday. RN-G stated the black/brown substance under her fingernails was feces and further went on to explain that R69 had a habit of digging at her buttocks after she had bowel movement (BM). R69's last BM was that morning. At 1:44 p.m. an interview with the assistant director of nursing (ADON) explained due to the behavior, interventions were put in place for staff to change and check R69 every 2 hours and provide nail care. On 4/28/16, at 8:34 a.m. the ADON verified R69's nails were dirty with feces.

R336's care plan dated 2/8/16, indicated R336 required one staff assist for grooming and licensed nurses to provide toenail and fingernail care each week.

On 4/25/16, at 3:51 p.m. R336 was observed to have long visible white facial hair along the underside of her chin. Her fingernails had a black substance underneath them and were long and jagged. R336 said "I can't tell if I have hair on my chin I can't see it." R336 explained staff would shave her if asked.

On 4/26/16, at 10:24 a.m. family member (FM)-B was visiting and stated R336 had a razor in her bathroom for staff to use. She staff don't shave R336 regularly.

On 4/27/16 at 9:34 a.m. R336 was observed to still have long facial hair along her chin and dirty fingernails.

On 4/27/16 at 9:56 a.m. NA-C stated she regularly took care of R336 and was proving care

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F 282	Continued From page 13 for her today. NA-C stated she did not see any facial hair on R336's chin while washing her face this morning. Upon looking at R336, NA-C verified seeing facial hair on R336's chin and her nails were dirty. RN-G walked into R336's room and explained R336 did not get her face shaved on a daily basis. At 10:07 a.m. the ADON verified R336's nails were in need of cleaning, cutting and trimming. R18's care plan, dated 3/29/16, indicated R18 was to be clean and well groomed daily. R18 was observed on 4/29/16 8:48 a.m. to have long dirty fingernails with heavy dark soil under all fingernails. R18 stated he did not want long fingernails and should have had them cut. RN-D verified R18's un-clean and long fingernails at the time of the observation. RN-D stated R18 got a shower on Friday of last week and verified the nails could not have grown that long in one week. The facility's Policy and Procedure titled "Grooming/Hygiene Cares" with a revision date of 12/11/12, indicated residents grooming will be performed with morning and evening cares and as needed. Care include shaving both males and females, fingernails cleaned and manicured. If the resident was diabetic nail care would be performed by a licensed nurse.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		6/8/16

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F 312	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure shaving and nail care were provided for 3 of 5 residents (R69, R336, R18) reviewed for activities of daily living (ADL's) and were dependent on staff for assistance. Findings include: R69 was eating breakfast in the dining room on 4/27/16, at 7:33 a.m. R69's fingernails and cuticles on both hands were imbedded with a dry dark black/brown substance. Later that day at 1:15 p.m. R69 was in the dining room and her fingernails remained soiled. A short time later a nursing assistant (NA)-B explained she was going to assist R69 to lie down for a rest. The resident was then assisted to bed by NA-B, but no other care was provided for R69 at that time. On 4/27/16 at 1:39 p.m. registered nurse (RN)-G stated R69 received nail care almost everyday. RN-G stated the black/brown substance under her fingernails was feces due to the resident's habit of digging in her rectum following a bowel movement (BM). R69's last BM was that morning. On 4/27/16, at 1:44 p.m. the assistant director of nursing (ADON) verified she was aware R69 often had fecal matter under her fingernails due to scratching her buttocks. The ADON explained that interventions had been put into place which included staff to check and change the resident every two hours and provide nail care. When the ADON and surveyor went into R69's room NA-B	F 312	"R336, R18 and R69 have received necessary services to maintain good grooming and personal hygiene, including nail care and facial hair removal. "All residents who are unable to carry out activities of daily living will receive the necessary service to maintain grooming and personal hygiene, including nail care and facial hair removal. "Nursing staff have been educated on the facility Grooming/Hygiene Cares policy and procedure, including removal of facial hair and having nails be cleaned and manicured. "Monitoring to ensure compliance will be conducted by the DON or designee through weekly audits of nail care and grooming. "The Facility QAPI committee will review the status of the grooming and nail care audits for further recommendations.	

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was still in the room. R69 was scratching her buttocks and reported, "It's itchy." The ADON instructed NA-B to use a wet wipe to clean her fingernails.

R69's Minimum Data Set (MDS) dated 2/15/16, indicated R69 required staff assistance with personal hygiene. R69's care plan dated 3/25/14, identified interventions of staff assist of 1 with ADL's and to thoroughly wash hands and under nails due to often digging and smearing Bowel Movement (BM).

A review of R69's Weekly Bath Audit sheet between 10/14/15 and 4/27/16, indicated R69 only received nail care twice on 3/21/16 and 4/27/16 after the ADON was informed of the grossly soiled fingernails.

A follow-up interview on 4/28/16, at 8:34 a.m. the ADON verified R69's nails yesterday were soiled with feces. The ADON explained that if a staff member saw a resident with dirty hands and/or fingernails they should offer the wet wipes that are at each dining room table and offer assistance if they need it. The ADON verified she expected her staff to be doing this and no resident should be eating at the table with dirty or soiled hands.

R336's physician's orders dated 3/11/16, indicated a diagnoses of Type 2 diabetes mellitus, dementia and Alzheimer's. R336's care plan dated 2/8/16, indicated R336 required one staff assist for grooming and licensed nurses to provide toenail and fingernail care each week.

On 4/25/16, at 3:51 p.m. R336 was observed to be unshaven and had long dirty jagged

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fingernails. R336's had long white facial hair along the underside of her chin. Under her fingernails was a black substance. R336 said "I can't tell if I have hair on my chin I can't see it." R336 explained staff would shave her when asked.

On 4/26/16, at 10:24 a.m. R336's family member (FM)-B was visiting and stated R336 had a razor in her bathroom for staff to use. FM-B didn't know why staff didn't shave her regularly.

On 4/27/16 at 9:34 a.m. R336 was observed sitting up in bed eating her breakfast. RN-G came into R336's room to bring her coffee. R336 continued to have the same long facial hair along her chin and dirty fingernails.

On 4/27/16 at 9:56 a.m. NA-C stated she regularly took care of R336 and was providing care for her today. NA-C explained after breakfast she took R336 to the bathroom and provided cares. NA-C verified she was done with R336's (ADL's) for the morning. NA-C stated the care provided to R336 included washing her face, combing her hair, incontinent cares if needed and oral cares. NA-C stated she did not see any facial hair on R336's chin while washing her face this morning. When R336 was observed, NA-C verified seeing facial hair on R336's chin and dirty nails. RN-G came into R336's room and explained R336 does not get her face shaved on a daily basis. RN-G asked R336 if she wanted to have her chin hairs shaved. R336 replied "it's fine" then said, "I guess I should mind I do have hair on my face." At 10:07 a.m. NA-C verified she had already provided grooming cares to R336. The ADON verified that R336 nails were in need of cleaning, cutting and trimming. The ADON

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explained R336 usually got a manicure weekly from the therapeutic recreation (TR) staff where they trim her nails. The ADON reviewed R336's weekly bath audits and identified R336 had not received nail care. The ADON explained on bath days the staff should be providing grooming cares to all resident which would include shaving and nail cares if needed. The cares should be documented on the bath sheets.

On 4/27/16 at 2:01 p.m. therapeutic recreation staff (TR)-A stated she had in the past provided manicures for R336. The last time R336 came to a manicure activity was 3/17/16. TR-A stated R336 had not attended the manicure activity for the last two weeks and didn't remember the last time she trimmed her fingernails.

A review of R336 Weekly Bath Audits sheets between 2/8/16 to 4/24/16, indicated R336 received nail care once on 2/8/16.

The facility's Policy and Procedure titled "Grooming/Hygiene Cares" revision date 12/11/12, indicated resident grooming will be preformed with morning and evening cares and as needed. Care included shaving both males and females, fingernails cleaned and manicured. If a diabetic resident nail care will be preformed by a licensed nurse.
R18's admission Minimum Data Set (MDS) assessment, dated 3/22/16, indicated R18 required extensive assistance with personal hygiene. The care area assessment, related to activities of daily living, indicated to proceed to care plan development in order to provide comfort and dignity for R18. The care plan, dated 3/29/16, indicated R18 was to be clean and well groomed daily.

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F 312	Continued From page 18 On 4/29/16, at 8:48 a.m. R18 was observed with long, dirty fingernails with heavy dark soil under all nails. The observation was verified by RN-D, at the time of the observation. RN-D explained R18 was on hospice and received 2 baths per week, a bed bath from hospice staff and shower from the facility staff. RN-D verified R18's bath day was scheduled for Wednesdays and nail care would be a part of regular bathing hygiene and daily hygiene as needed. The electronic health record indicated a bath was to be completed by the facility on Wednesdays. Documentation for completion of a bath was blank for 4/6/16 and 4/13/16. RN-D explained there had been a computer problem that had since been corrected. The documentation on 4/27/16 indicated R18 had refused a bath. RN-D stated R18 got a shower on Friday of last week and verified the nails could not have grown that long in one week. RN verified nail care would be included as part of a bed bath. The facility's Policy and Procedure titled "Grooming/Hygiene Cares" with a revision date of 12/11/12, indicated residents grooming will be performed with morning and evening cares and as needed. Care included shaving both males and females, fingernails cleaned and manicured. If the resident was diabetic, nail care would be performed by a licensed nurse.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		6/8/16

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F 329	Continued From page 19 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide orthostatic blood pressure monitoring for 1 of 5 residents on an antipsychotic medication (R535) and reviewed for unnecessary medications. Findings include: R535 was admitted to the facility on 2/3/16. R535's initial Minimum Data Set (MDS) dated 2/8/16, indicated the resident was prescribed antipsychotic medication (for psychosis) in the 7-day assessment period for the diagnosis of non-Alzheimer's dementia. The 2/8/16, MDS also	F 329	"R535□s orthostatic blood pressure has been completed. "All residents receiving antipsychotic medications who have an order for orthostatic blood pressure had orthostatic blood pressure□s completed. "Licensed nursing staff have been educated on the requirement to take orthostatic blood pressure for residents per MD order. "Monitoring to ensure compliance will be conducted by the DON or designee through weekly audits of the medical record for residents receiving	

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F 329	Continued From page 20 indicated R535 was also prescribed antidepressant and anti-anxiety medications. Review of R535's physician orders upon admission dated 4/3/16, indicated R535 had started on an antipsychotic medication Seroquel 12.5 mg (milligrams) twice a day for psychosis. The physician order directed staff to check the orthostatic blood pressures for R535 daily for three days. Review of R535's TAR where orthostatic BP's were recorded indicated the order was not followed. There were no orthostatic BP's. Review of R535's physician orders dated 4/27/16, indicated to correct the diagnosis for medications Midodrine (increases BP) and Fludrocort (steroid) from hypertension to orthostatic hypotension (drop in BP upon rising). The physician order dated 4/28/16, directed staff to take R535's orthostatic BP every month on the 27th. Review of the consulting pharmacist (CP) Communication to Nursing identified a nursing recommendation dated 3/8/16, "This resident has an order for antipsychotic med. Guidelines require the following monitoring for this category of meds: ... Monthly or quarterly Ortho-BP" and nursing recommendation dated 4/4/16, "This resident has an order for antipsychotic med. Guidelines require the following monitoring of this category of meds: ... "Monthly or quarterly Ortho-BP" Review of an incident report indicated on 4/9/16, at 5:00 a.m. R535 was found on the floor next to his bed. The incident report stated R535 had been reaching for a blanket on his wheelchair.	F 329	antipsychotic medications. "The Facility QAPI committee will review the status of the grooming and nail care audits for further recommendations.	

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F 329	Continued From page 21 On 4/27/16, at 9:35 a.m. R535 was observed standing alone in his room near his recliner with his walker. R535 stated he never felt dizzy. On 4/27/16, at 11:00 a.m. registered nurse (RN)-E verified R535's record did not indicate an orthostatic blood pressure (BP) had been taken for R535 since his admission to the facility. On 4/27/16, at 10:41 a.m. nurse practitioner (NP) stated if a resident was ambulatory and on an antipsychotic medication she recommended orthostatic blood pressures be taken monthly for that resident. On 4/27/16, at 12:40 p.m. RN-D stated R535 had diagnoses of progressing Parkinson's and psychosis. R535 had fallen at home and had a couple of falls after admission to the facility but had been doing well lately. RN-D stated it was the pharmacist who would tell the facility which residents were to have an orthostatic BP taken. RN-D stated that an orthostatic BP's had not been discussed at the daily meeting when falls were reviewed as a fall intervention for R535. RN-D waited for the CP to make a recommendation. RN-D verified on R535's 2/16, treatment administration record (TAR) the daily orthostatic BP's ordered for 3 days had not been completed. RN-D stated she would follow up. On 4/28/16, at 9:50 a.m. RN-D stated she called the NP. The NP had ordered monthly orthostatic BP's for R535. RN-D stated an orthostatic BP was taken last evening for R535. RN-D stated there was a 18 point drop in R535's systolic (the top number) BP. RN-D stated nurses were supposed to report to the physician or NP a drop of 10 points or more in the BP.	F 329		

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	245055	A. BUILDING _____ B. WING _____	04/29/2016

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F 329	Continued From page 22 On 4/28/16, at 9:55 a.m. RN-E stated nothing had been passed on in early morning report about a drop in systolic BP for R535. There was also nothing on the 24 hour report board about it. RN-D then stated there was no progress note nor evidence of any call to the NP or physician regarding the drop in BP for R535. RN-D stated she would follow up with it. On 4/28/16, at 10:03 a.m. on 4/28/16, RN-E stated she would not call the NP or physician related to a BP issue unless there were parameters set to call them. RN-E stated she was not aware of R535's diagnosis of orthostatic hypotension or of R535's previous falls at home. RN-E stated R535 was a fall risk in at admission but R535 had not had any falls in a long time. On 4/28/16, at 10:09 a.m. licensed practical nurse (LPN)-A stated she would call the NP or physician if a resident's BP dropped 8 points or more and would chart it in a progress note. LPN-A stated R535 had hypotension (low BP), and that R535's BP's did not run high because of the medications he took. On 4/28/16, at 10:24 a.m. LPN-B stated she would call the NP or physician if the systolic BP was less than 100 or if there were NP or physician ordered parameters. LPN-B stated it "depended on what the resident's baseline BP was." On 4/28/16, at 12:09 p.m. the CP said he came to the facility every month to review residents' medications. The CP stated on the 3/8/16 visit, he made a recommendation to the facility for monthly or quarterly orthostatic BP's to be taken	F 329		

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F 329	Continued From page 23	F 329		

for R535. The CP stated nurses can make a clinical judgement on how often to take the orthostatic BP's. The CP stated the facility usually asked the NP how often to take them and the NP would write the order. The CP stated he had seen the order the NP had written upon admission for R535 in early February for orthostatic BP's to be taken daily for 3 days. The CP identified the orthostatic BP's ordered had not been done. The CP stated he made the BP recommendation in 3/16. The CP also stated he had emailed the interim director of nursing (IDON) on 4/5/16, that R535 needed an orthostatic BP's taken. The CP stated a NP or physician should be informed of a 10-20 point drop in systolic BP during an orthostatic BP.

On 4/28/16, at 1:35 p.m. the assistant director of nursing (ADON) stated she expected the nurse manager to schedule the orthostatic BP on the TAR and to follow up to make sure it was done. The ADON also stated upon receiving the nursing recommendation she would expect the nurse manager to clarify with either the NP or the CP which time frame (monthly or quarterly) would be appropriate for the resident. The ADON stated the NP made the decision. The ADON stated the nurse would have to notify the NP if there was a significant change in the BP when taking an orthostatic BP. The facility did not follow a specific guideline of when to call the practitioner. The ADON stated she would have contacted the NP on R535's 18 point drop in systolic BP because of his needs. He had a diagnosis of orthostatic hypotension and was on an antipsychotic medication. The ADON stated falls were discussed daily at standup, the nurse managers put the fall interventions in place and she was not aware of any discussions regarding

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F 329	Continued From page 24 R535's blood pressure.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure safe food handling procedures were followed in the kitchen This had the potential to affect all 289 residents in the facility. Findings include: During a revisit to the kitchen on 4/27/16, at 11:03 a.m. food service worker (FSW)-C, a cook and assistant supervisor, were observed working with bare hands while making multiple grilled cheese sandwiches. Slices of bread and cheese were laid out to be closed up and put in a pan for heating. FSW-C ran out of cheese, and went to the cooler for more. FSW-C grabbed the handle to the cooler door, entered to get the package of sliced cheese, and brought it back to the prep counter. Without stopping for handwashing, FSW-C reopened the plastic-wrapped cheese, peeled slices out of the package, and began	F 371	"The grilled cheese sandwiches were discarded immediately. "All food will be handled according to the facility policy and procedure to ensure safe food handling procedures. "Culinary staff have been educated on the facility policy and procedure for culinary infection control which includes the expectations for proper handwashing and food handling procedures. "Monitoring to ensure compliance will be conducted by the Administrator or designee through weekly audits of the food preparation and handling process. "The facility QAPI committee will review the status of the food preparation and handling audits for further recommendations.	6/8/16

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F 371	Continued From page 25 laying them on buttered bread slices sitting on the prep counter. When about handwashing FSW-C stated there was no need to, as the handle got wiped down at the start and end of the shift. When asked specifically if hands should be washed when coming back from the cooler to work on food prep FSW-C said "Yes." FSW-C acknowledged hands had not been washed then stated again, "We wipe the handle of that cooler down at the beginning and end of the shift." The Infection Control Culinary Services policy revised 7/11/12, indicated "Culinary Services Staff Members:..Will practice proper food handling procedures, including but not limited to hand washing..." On 4/27/16 at 11:21 a.m. FSW-D, a kitchen supervisor said, "Yes, I would expect to see handwashing after a kitchen worker goes to the cooler and touches the handle before resuming food handling."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		6/8/16

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F 428	Continued From page 26 by: Based on observation, interview and document review the facility failed to ensure the consulting pharmacist's recommendations were acted upon related to orthostatic blood pressure monitoring for 1 of 5 residents on an antipsychotic medication (R535) reviewed for unnecessary medications. Findings include: R535 was admitted to the facility on 2/3/16. R535's initial Minimum Data Set (MDS) dated 2/8/16, indicated the resident was prescribed antipsychotic medication (for psychosis) in the 7-day assessment period for the diagnosis of non-Alzheimer's dementia. The 2/8/16, MDS also indicated R535 was also prescribed antidepressant and anti-anxiety medications. Review of R535's physician orders upon admission dated 4/3/16, indicated R535 had started on an antipsychotic medication Seroquel 12.5 mg (milligrams) twice a day for psychosis. The physician order directed staff to check the orthostatic blood pressures for R535 daily for three days. Review of R535's TAR where orthostatic BP's were recorded indicated the order was not followed. There were no orthostatic BP's. Review of R535's physician orders dated 4/27/16, indicated to correct the diagnosis for medications Midodrine (increases BP) and Fludrocort (steroid) from hypertension to orthostatic hypotension (drop in BP upon rising). The physician order dated 4/28/16, directed staff to take R535's orthostatic BP every month on the 27th.	F 428	"R535□s orthostatic blood pressure has been completed. "All residents receiving antipsychotic medications with a pharmacy recommendation to monitor orthostatic blood pressure have had a orthostatic blood pressure completed. "Nurse managers have been educated on the requirements for processing and tracking pharmacy recommendations related to orthostatic blood pressure monitoring. "Monitoring to ensure compliance will be conducted by the DON or designee through weekly audits of the pharmacy recommendations related to orthostatic blood pressure monitoring. "The facility QAPI committee will review the status of the pharmacy recommendation audits for further recommendations.	

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F 428	Continued From page 27 Review of the consulting pharmacist (CP) Communication to Nursing identified a nursing recommendation dated 3/8/16, "This resident has an order for antipsychotic med. Guidelines require the following monitoring for this category of meds: ... Monthly or quarterly Ortho-BP" and nursing recommendation dated 4/4/16, "This resident has an order for antipsychotic med. Guidelines require the following monitoring of this category of meds: ... "Monthly or quarterly Ortho-BP" Review of an incident report indicated on 4/9/16, at 5:00 a.m. R535 was found on the floor next to his bed. The incident report stated R535 had been reaching for a blanket on his wheelchair. On 4/27/16, at 9:35 a.m. R535 was observed standing alone in his room near his recliner with his walker. R535 stated he never felt dizzy. At 11:01 a.m. R535 walked down the hall, steady and unassisted with his wheeled walker toward the dining room. At 12:30 p.m. R535 stood by the dining room table with his walker, adjusted his pants and sat down at the table independently. On 4/27/16, at 11:00 a.m. registered nurse (RN)-E stated R535 was not a fall risk. R535 had fallen when he first came to the facility but walked pretty steady. RN-E also verified R535's record did not indicate an orthostatic blood pressure (BP) had been taken for R535 since his admission to the facility. On 4/27/16, at 10:41 a.m. nurse practitioner (NP) stated if a resident was ambulatory and on an antipsychotic medication she recommended orthostatic blood pressures be taken monthly for that resident.	F 428		

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F 428	Continued From page 28 On 4/27/16, at 12:40 p.m. RN-D stated R535 had diagnoses of progressing Parkinson's and psychosis. R535 had fallen at home and had a couple of falls after admission to the facility but had been doing well lately. RN-D stated R535 was steady on his feet. RN-D stated it was the pharmacist who would tell the facility which residents were to have an orthostatic BP taken. Additionally, an orthostatic BP might be used as a fall intervention. RN-D stated that an orthostatic BP's had not been discussed at the daily meeting when falls were reviewed as a fall intervention for R535. RN-D waited for the CP to make a recommendation. RN-D stated she was not aware of a recommendation from the CP for an orthostatic BP to be taken for R535. RN-D verified on R535's 2/16 treatment administration record (TAR) that the daily orthostatic BP's ordered for 3 days for R535 had not been completed. RN-D also verified the rationale for two medications for blood pressure were incorrectly identified on the medication administration record (MAR) for a diagnosis of hypertension (high BP) rather than orthostatic hypotension (drop in BP with changes in position). RN-D stated she would follow up. On 4/28/16, at 9:50 a.m. RN-D stated she called the NP. The NP had changed the diagnosis back to orthostatic hypotension and ordered monthly orthostatic BP's for R535. RN-D stated an orthostatic BP was taken last evening for R535. RN-D stated there was a 18 point drop in R535's systolic (the top number) BP. RN-D stated nurses were supposed to report to the physician or NP a drop of 10 points or more in the BP. On 4/28/16, at 9:55 a.m. RN-E stated nothing had	F 428		

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F 428	Continued From page 29	F 428		

been passed on in early morning report about a drop in systolic BP for R535. There was also nothing on the 24 hour report board about it. RN-D then stated there was no progress note nor evidence of any call to the NP or physician regarding the drop in BP for R535. RN-D stated she would follow up with it.

On 4/28/16, at 10:03 a.m. on 4/28/16, RN-E stated she would not call the NP or physician related to a BP issue unless there were parameters set to call them. RN-E stated she was not aware of R535's diagnosis of orthostatic hypotension or of R535's previous falls at home. RN-E stated R535 was a fall risk in at admission but R535 had not had any falls in a long time. RN-E stated R535 was now stable on his feet as long as he walked with his walker. RN-E stated R535 was independent with transfers and ambulation.

On 4/28/16, at 10:09 a.m. licensed practical nurse (LPN)-A stated she would call the NP or physician if a resident's BP dropped 8 points or more and would chart it in a progress note. LPN-A stated R535 had hypotension (low BP), and that R535's BP's did not run high because of the medications he took.

On 4/28/16, at 10:24 a.m. LPN-B stated she would call the NP or physician if the systolic BP was less than 100 or if there were NP or physician ordered parameters. LPN-B stated it "depended on what the resident's baseline BP was."

On 4/28/16, at 12:09 p.m. the CP said he came to the facility every month to review residents' medications. The CP stated on the 3/8/16 visit, he

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F 428	Continued From page 30	F 428		

made a recommendation to the facility for monthly or quarterly orthostatic BP's to be taken for R535. The CP stated nurses can make a clinical judgement on how often to take the orthostatic BP's. The CP stated the facility usually asked the NP how often to take them and the NP would write the order. The CP stated he had seen the order the NP had written upon admission for R535 in early February for orthostatic BP's to be taken daily for 3 days. The CP identified the orthostatic BP's ordered had not been done. The CP stated he made the BP recommendation in 3/16. The CP also stated he had emailed the interim director of nursing (IDON) on 4/5/16, that R535 needed an orthostatic BP's taken. The CP stated a NP or physician should be informed of a 10-20 point drop in systolic BP during an orthostatic BP.

On 4/28/16, at 1:35 p.m. the IDON stated she had been the IDON since mid January and now as of a few days ago was the assistant director of nursing (ADON). The ADON stated the CP came to the facility once a month to review all the residents' medications. The ADON stated the CP typically mailed the recommendations to her within 3 days of his visit and she gave the hard copy of the recommendation to each nurse manager by the next business day. The ADON stated the CP had been at the facility on 4/5/16. The ADON stated she expected the nurse manager to schedule the orthostatic BP on the TAR and to follow up to make sure it was done. The ADON also stated upon receiving the nursing recommendation she would expect the nurse manager to clarify with either the NP or the CP which time frame (monthly or quarterly) would be appropriate for the resident. The ADON stated the NP made the decision. The ADON stated the

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F 428	Continued From page 31 nurse would have to notify the NP if there was a significant change in the BP when taking an orthostatic BP. The facility did not follow a specific guideline of when to call the practitioner. The ADON stated she would have contacted the NP on R535's 18 point drop in systolic BP because of his needs. He had a diagnosis of orthostatic hypotension and was on an antipsychotic medication. The ADON stated falls were discussed daily at standup, the nurse managers put the fall interventions in place and she was not aware of any discussions regarding R535's blood pressure. The policy provided by the facility dated 10/22/13, Monthly Medication Review indicated "The MRR (medication regimen review) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician. Recommendations are acted upon and documented by the facility staff and/or the prescriber. The director of nursing or designated licensed nurse will address and document recommendations that do not require physician intervention (e.g., Vital sign monitoring, labs, PRN documentation.)."	F 428		
F 431 SS=D	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	F 431		6/8/16

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F 431	Continued From page 32 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 review, the facility failed to ensure the medication cart was locked on 1 of 2 medication carts (Gamble), observed during a random observation. Had the potential to affect all 20 residents on the unit.	F 431	"The medication cart was locked at the time of the survey. "All medication carts will be locked when not attended to. "Licensed nursing staff have been educated on the requirement to lock medication carts when not attended to.	

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F 431	Continued From page 33 Findings include: On 4/25/16 at 6:47 p.m. during a random observation, medication cart # 3 located on the 3rd floor (Gamble) was unlocked and their was no staff nurse around the medication cart # 3 until 6:57 p.m. when registered nurse (RN)-B was informed that medication was unlock. On 4/25/16 at 6:57 p.m. RN-B confirmed that the medication cart # 3 was unlocked and stated her expectation is if there is no nurse at the medication cart, it should be locked. In addition, RN-B mentioned, "there are 6 residents whose medication are kept in this medication cart." On 4/27/16 at 10:54 a.m. assistant director of nursing stated "My expectation is that medication cart is to be locked whenever they left unattended." Polic and procedure titled MEDICATIION STORAGE IN THE FACILITY dated 10.23.13, reads, "1. Medication rooms, carts and supplies are locked, and only licensed nurses, the COnsultant Pharmacist and those lawfully authorized are allowed access to medications. Each nurse authorized to use medicine room or cart keys must carry these keys at all times while on duty. These keys are not to be left in a drawer or loaned out for any reason."	F 431	"Monitoring to ensure compliance will be conducted by the DON or designee through weekly audits of the medication cards. "The facility QAPI committee will review the status of the food preparation and handling audits for further recommendations.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		6/8/16

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	245055	A. BUILDING _____ B. WING _____	04/29/2016

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F 441	Continued From page 34 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review,the facility failed to implement effective infection control procedures during morning cares for 1 of 1 resident (R176) reviewed on clostridium difficile (c-diff) colitis precautions. Findings include:	F 441	"Resident 176 is no longer in isolation for C-Diff. "All residents with a diagnosis of C-Diff will be provided with a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. "Licensed Nursing staff and NAR□s have	

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F 441	Continued From page 35 R176's nurse practitioner (NP) visit notes, dated 4/22/16, revealed the following diagnoses: clostridium difficile colitis, recurrent UTI, and pressure ulcers. The NP further noted "Still having loose stools about 2-3 times per day." A form entitled "THIS PATIENT IS ON STRICT ISOLATION" dated 4/12/16, revealed R176 was on isolation precautions for c-diff beginning 4/12/16 and those precautions had not been discontinued. On 4/28/16, at 9:45 a.m. the nurse manager (RN)-F and a nursing assistant, (NA)-A were observed assisting R176 with morning cares in her room. RN-F and NA-A were observed to don shoe covers, gowns and gloves prior to entering the room. RN-F was observed to put lotion on R176's bottom. RN-F then removed her gloves and donned new gloves, without performing hand hygiene, and continued to assist NA-A. NA-A cleaned R176's bottom. Wipes were noted to be red tinged. NA-A reported she needed more incontinence briefs. RN-F reported she would get them. RN-F was then observed to remove her gown, shoe covers and gloves, open the door and leave the room. RN-F did not perform hand hygiene prior to opening the door and leaving room. RN-F was observed to put hand sanitizer gel on her hands at a nearby medication cart. The door knob was not sanitized after completion of cares. RN-F returned to room with disposable briefs and was wearing a gown, gloves and foot covers. RN-F applied cream to R176's bottom. RN-F then removed her gloves, placed the gloves in the garbage. RN-F donned new gloves, without first completing hand hygiene. R176 asked for the phone. RN-F handed her the phone with gloved hands. R176 used the phone. NA-A informed	F 441	been educated on the Isolation precautions for C-Diff, the facility policy on Hand washing/Hand Hygiene. "Monitoring to ensure compliance will be conducted by the DON or designee through weekly audits by observing Isolation precautions, hand washing and hand hygiene. "The facility QAPI committee will review the results of the audits quarterly for further recommendations.	

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F 441	Continued From page 36	F 441		

RN-F that R176's catheter bag was full. RN-F obtained a graduated cylinder from the bathroom. No hand hygiene was performed or gloves changed. RN-F emptied the catheter bag into the graduated cylinder without first wiping the spigot clean. RN-F then emptied the cylinder into the toilet, removed her gloves and donned new gloves. No hand hygiene was performed between glove changes. RN-F then assisted NA-A with putting clothes on R176. NA-A identified she needed to swap out mechanical lifts. NA-A removed her gown, shoe covers and gloves, opened the door and left the room without performing hand hygiene. NA-A returned with a mechanical lift and was again wearing a gown, gloves and protective shoe covers. RN-F then straightened out pillows on the bed and assisted NA-A with using the mechanical lift to transfer R176 to the wheelchair. NA-A straightened the linen on the bed while RN-F brushed R176's hair with gloved hands. RN-F did not perform hand hygiene between performing catheter cares and assisting R176 to transfer and brushing her hair. During cares R176 expressed frustration over a cycle of c-diff infections and urinary tract infections. Upon completion of cares, RN-F reported she used hand sanitizer between glove changes and after leaving the room. RN-F was unable to locate the hand sanitizer she used. RN-F reported she used the washcloth to clean the spigot of the catheter. RN-F reported she thought she needed to wash hands only after cares were completed and hand sanitizer was ok between glove changes and while briefly leaving the room to get supplies. RN-F reported R176 was on c-diff precautions but she was hoping they could be discontinued soon.

On 4/28/16 at 2:38 p.m. the director of nursing

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(DON) was informed of the infection control concerns. The DON reported she was unfamiliar with facility policy and procedure as she was newly hired. The DON reported she would expect staff to follow the infection control policies and procedures.

The Hand washing/Hand Hygiene policy, dated 4/20/12, directed staff "Handwashing Indications: A. When providing resident care 1) Before you begin and after any care 2) Between residents in your care 3) Before putting on gloves and after removing them 4) After touching blood or other body substances 5) After touching any potentially contaminated objects such as dressings, catheters, bedpans, basins, clothing or linen, specimen container and so forth"

The Clostridium Difficile Infection policy, last revised 7/27/12, directed staff "Transmission-based precautions 1) C. Diff is shed in feces. a. Any surface, device or material (such as commodes, bathing tubs and electrical rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the C. diff spores. b. C. Diff spores are transferred to patients mainly via hands that have touched a contaminated surface or item. c. Reinforce Standard Precautions with high emphasis on hand washing. 2. Initiate Contact Precautions for all symptomatic and asymptomatic residents when C. Diff is suspected or diagnosed. a. Place these residents in private rooms. If private rooms are not available, these residents can be cohorted with other residents with C. Diff infection. b. Use gloves when entering resident's room and during resident care. c. Perform hand hygiene after removing gloves. d. Because alcohol does not kill C. Diff. spores, use of soap

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F 441	Continued From page 38 and water is more efficacious than alcohol-based hand rubs." The Catheter Care-Indwelling policy, last revised 8/1/13, directed staff to "wash hands/perform hand hygiene" and "F. Apply soap to the second washcloth to wash the catheter. G. Wiping downward away from urethral opening, cleanse approximately 2-3 inches of catheter tubing. Firmly grasp the catheter to prevent tugging on it and gently wash the tubing. and "4) Gently dry the tubing." and "remove gloves, wash hands"	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents room doors were in good repair. In addition the facility failed to ensure ceiling lights were free from insects (ladybugs). This had the potential to affect multiple residents on 2 units (1 Rains, 6 Gamble). Findings include: During multiple resident interviews on 4/25/16 and 4/26/16, with R165, R293, R318 and R335 it was observed all the resident ceiling lights had many dead ladybugs in them.	F 465	"R165, R293, R318, and R335□s ceiling lights are free from insects. R15, R17, R235, R300, R438 and R535□s room doors have been repaired and are free from scratches and/or gouges. R235□s bathroom door has been repaired and is free from scratches and/or gouges. The ceiling lights on 1 Raines are free from insects. The 2 ceiling lights in the dining room on 1 Raines are free from insects. "Resident room ceiling lights are free from insects. A weekly plan has been developed to address the scratches and gouges on resident room doors and bathrooms by July 31st, 2016. Ceiling	6/8/16

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F 465	Continued From page 39 On 4/25/16, at 7:09 p.m. R165 stated to the surveyor "I wish you could do something about all these bugs," as she pointed to some live ladybugs crawling on her floor under her bedside tray table. R165 explained there is an infestation of bugs "the other day behind by the video stand was a pile of dead ladybugs on the floor." R165 said, "I feel it's a cleanliness thing more than anything." During the environmental tour on 4/28/16, at 9:05 a.m. the following staff was present, maintenance supervisor (MS), director of nursing (DON) and housekeeper/laundry supervisor (HS/LS). The following was noted: 1. Multiple ceiling lights leading to the dining room on 1 Rains contained many dead ladybugs in the ceiling lights. 2. 2/3 of one of the ceiling lights in the dining room on 1 Rains contained live and dead ladybugs crawling along inside the ceiling light fixture where residents eat their meals. 3. Resident (R165, R293, R318, R335) ceiling lights had dead ladybugs in them. 4. Resident (R15, R17, R235, R300, R438, R535) doors on the floors 4, 5, and 7 Gamble had long scratch marks that went along the bottom 2/3 of the door. There were nicks and large gouges of wood missing from the doors. 5. R235's bathroom door was scratched up and missing approximately half the paint. 6. R438 stated "This door has been like this since I moved in [1/27/15] I go straight in/out and do not	F 465	lights on resident units and in the dining rooms are free from insects. "The facility pest control policy has been reviewed and updated as necessary. Facility staff have been educated on the pest control policy, use of the Work Request email, front desk logs, or unit work request binders to communicate concerns regarding insects in the ceiling lights or damage to resident room and bathroom doors. Maintenance staff have been educated on the expectation that all resident room and bathroom doors will be free from scratches and gouges and in good repair. "Monitoring to ensure compliance will be completed by the Administrator or designee through weekly audits of the resident room and bathroom doors and all ceiling lights. "The facility QAPI committee will review the status of the resident room and bathroom door and ceiling light audits for further recommendations.	

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hit the door." The door was observed to have multiple scratches the length of her door with 3 large gouges on the side of her door.

The three staff present during the tour verified the live and dead bugs in the ceiling light fixtures were ladybugs. All three staff presents verified residents should not have to look up while eating or in their rooms and see dead bugs. The HS/LS explained he was aware of the ladybug issues throughout the facility. HS/LS verified the facility pest control company did not have any solution to control the ladybugs other than his staff vacuuming them up when needed. HS/LS verified that dining room ceiling light on 1 Rains should have been taken care of right away.

The three staff present during the tour verified the doors were not in good conditions and were in need of repairs. The MS explained if staff or nursing saw an issue they would fill out a work order either on line, paper form or let the front desk know. Maintenance staff was informed of the concern. The MS stated he did have a preventive maintenance plan but it was more related to cleaning the vents, monitoring fire drills and more mechanical type items. The HS/LS explained any doors with deep gouges would be taken off and sanded down. The MS stated he had not received any request for doors in need of repair. The MS explained his staff watched for things that needed repair, "we do a facility walk through of a couple of floors a week." The MS further indicated there had been a sheet of which floors were toured and what things needed repair but that was no longer done. The MS could not identify the last time he or his staff did a walk through nor which floors were done.

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F 465	Continued From page 41 A review of the facility's pest control book from Adams pest control, Inc. indicated under "Customer pest sighting," on 10/13/15, 4/21/16 and 4/26/16 ladybugs were seen on 4 gamble and the conference room by the dental office. The service date by Adams pest control Inc. was 11/9/15, and indicated action taken was exterior treatment, recommend using vacuum for interior units and common area. The facility did not have a policy or procedure for internal pest control.	F 465		

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	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**04/28/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 28, 2016. At the time of this survey, Walker Methodist Health Center was found not 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 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/20/2016

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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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Walker Methodist Health Center is a 7-story building with a full basement. The building was constructed at 2 different times. The original 5 story building was constructed in 1964 and was determined to be of Type II(222) construction. In 1983, a 7 story addition was constructed to the North that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. This building has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 320 beds and had a census of 290 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		6/8/16

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K 029 SS=E	Continued From page 2 One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 9:00 AM 3:30: PM on April 28, 2016, it was observed that 1) The self-closing doors to the commercial laundry room in the basement are held open with devices that are not tied into the fire alarm system and 2) The laundry room door on the 2nd floor Gamble, does not positively latch. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 029	"The self-closing doors leading to the commercial laundry will have devices added and tied to the buildings fire alarm system. The 2nd floor Gamble laundry room door has been fixed to close and positively latch. "All maintenance staff have been educated on the requirements of corridor doors to close and positively latch. All staff have been educated on the requirement for no doors to be held open by non-approved devices. "Monitoring to ensure compliance will be completed by the Maintenance Supervisor or designee through random audits of self-closing doors and corridors doors latching function. "The Facility QAPI committee will review the status of the grooming and nail care audits for further recommendations.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on document review and staff interview,	K 046	"The battery operated emergency egress	6/8/16

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K 046	Continued From page 3 the facility failed to provide adequate emergency lighting in accordance with LSC (00) 19.2.8. This deficient practice can effect all 29 residents. Findings include: On a facility tour between 9:00 AM and 3:30 PM on April 28, 2016, it was observed that the facility could not provide documentation of testing records for the battery operated emergency egress lighting. This deficient practice was verified by the Director of Maintenance at the time of the discovery.	K 046	lighting has been tested with test results documented. "A Documentation log was created for the recording of the testing of all battery operated emergency egress lighting. "All maintenance staff have been educated on the requirements of testing and recording of the battery operated emergency egress lighting. "Monitoring to ensure compliance will be completed by the Maintenance Supervisor or designee through random audits of the emergency lighting testing documentation log. "The Facility QAPI committee will review the status of the emergency lighting testing documentation audits for further recommendations.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 44 residents. Findings include: On facility tour between 9:00 AM and 3:30 PM on April 28, 2016, It was revealed that 1)The current smoke detector sensitivity test on file is dated 02/10/2014, which is past due and 2) The facility did not provide evidence of inspections for battery operated smoke alarms.	K 054	"The smoke detector sensitivity test has been completed. All battery operated smoke alarms have been inspected. "The smoke detector sensitivity test will be completed annually and results documented. All battery operated smoke alarms will be inspected annually and results documented. "All maintenance staff have been educated on the requirement to complete the smoke detector sensitivity test annually and the testing and documentation of all battery operated smoke alarms annually. "Monitoring to ensure compliance will be	6/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING **01 - BUILDING 01** B. WING _____	**04/28/2016**

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WALKER METHODIST HEALTH CENTER	**3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409**

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K 054	Continued From page 4 This was confirmed by the Director of Maintenance at the time of discovery.	K 054	completed by the Maintenance Supervisor or designee through random audits of the smoke detector sensitivity test documentation and the battery operated smoke detector inspection documentation. "The Facility QAPI committee will review the status of the smoke detector testing documentation audits for further recommendations.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, policy review and staff interview, the facility failed to follow policy for the designated resident smoking in accordance with NFPA LSC (00) Edition Section 19.7.4, and the facility's smoking policy. This deficient practice	K 066	"The cigarette butts disposed of in the general use trash can have been removed and disposed of appropriately. "All cigarette butts will be disposed of properly according to designated smoking	6/8/16

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K 066	Continued From page 5 could affect all 298 residents. Findings include: On facility tour between 9:00 AM and 3:30 PM on April 28, 2016, It was observed that the were cigarette butts disposed of in a general use trash can in the designated employee smoking area. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 066	areas and the facility smoking policy. "All staff have been educated on the proper disposal of cigarette butts. All maintenance staff have been educated on the requirement of regular remove of all cigarette butt disposal containers. "Monitoring to ensure compliance will be completed by the Maintenance Supervisor or designee by completing random audits of the general use trash cans and cigarette butt disposal containers. "The Facility QAPI committee will review the status of the general use trash can and cigarette butt disposal container audits for further recommendations.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the medical gas storage in accordance with NFPA 99. This deficient practice could affect the residents. Findings include: On a facility tour on between 9:00 AM and 3:30 PM on April 28, 2016, observation revealed that there were three oxygen cylinders stored in room 2W24 which is not ventilated to the outside.	K 076	"The oxygen tanks were removed from room 2W24 and stored in designated oxygen storage room. "All oxygen tanks will be stored in the designated oxygen storage room in accordance with NFPA 99. "All staff have been educated on the facility policy and procedure regarding proper storage of oxygen tanks. "Monitoring to ensure compliance will be completed by the Maintenance Supervisor	6/8/16

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K 076	Continued From page 6 This deficient practice was verified by the Director of Maintenance at the time of the discovery.	K 076	or designee by completing random audits oxygen tank. "The Facility QAPI committee will review the status of the oxygen tank storage audits for further recommendations.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirements for the proper arrangement of room intended for the transferring of liquid oxygen from one container to another per NFPA 99 8-6.2.5.2. This deficient practice could affect all 44 residents. Findings include: On a tour of the facility between 9:00 AM and 3:30 PM on April 28, 2016, observation revealed that there were holes in the concrete ceiling of the	K 143	"The holes in the concrete ceiling of the 3 Gamble oxygen transfilling room exposing the post tension cables have been patched. "All ceiling holes in the oxygen transfilling rooms exposing post tension cables have been patched. "Maintenance staff have been educated on the requirement for oxygen transfilling rooms to have to open holes or exposure to post tension cables. "Monitoring to ensure compliance will be	6/8/16

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K 143	Continued From page 7 3rd floor Gamble oxygen transfilling room, that exposed the post tension cables. This deficient practice was verified by the Director of Maintenance at the time of the discovery.	K 143	conducted by the Maintenance Supervisor or designee through random audits of the oxygen transfilling room. "The Facility QAPI committee will review the status of the oxygen transfilling room audits for further recommendations.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 76 residents. Findings include: On a facility tour between 9:00 AM and 3:30 PM on April 28, 2016, observation revealed that 1) Weekly generator inspections were not conducted between the dates of March 22, 2016 and April 19, 2016 and, 2) There was no separate documented cool-down period during the monthly generator load tests. These deficient practices were verified by the Director of Maintenance at the time of the discovery.	K 144	"The weekly generator inspections have been completed and documented. The cool down period has been added to documentation of the monthly generator load tests. "All weekly generator inspections will be documented going forward. All cool down periods following the monthly load test will be documented going forward. "All maintenance staff have been educated on the requirements of maintaining the weekly generator inspection documentation and the cool down period of the monthly load test. "Monitoring to ensure compliance will be conducted by the Maintenance Supervisor or designee through random audits of the documentation logs. "The Facility QAPI committee will review the status of the generator documentation audits for further recommendations.	6/8/16
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2	K 147		6/8/16

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K 147	Continued From page 8 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to comply with NFPA 99 and NFPA 70 The National Electric Code. This deficient practice could affect the resident. Findings include: On a facility tour between 9:00 AM and 3:30 PM on April 28, 2016, observation revealed that an opening in the wall on the Raines, 5th floor, south side had live electrical wires exposed that were capped with wire nuts. This deficient practice was verified by the Director of Maintenance at the time of the discovery.	K 147	"The weekly generator inspections have been completed and documented. The cool down period has been added to documentation of the monthly generator load tests. "All weekly generator inspections will be documented going forward. All cool down periods following the monthly load test will be documented going forward. "All maintenance staff have been educated on the requirements of maintaining the weekly generator inspection documentation and the cool down period of the monthly load test. "Monitoring to ensure compliance will be conducted by the Maintenance Supervisor or designee through random audits of the documentation logs. "The Facility QAPI committee will review the status of the generator documentation audits for further recommendations.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 13, 2016

Ms.. Brooke Peoples, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5055026, H5055087, H5055191, H8055193, H5055194

Dear Ms.. Peoples:

The above facility was surveyed on April 25, 2016 through April 29, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers, H5055087, H5055191, H8055193, H5055194, that were found to be unsubstantiated. In addition one complaint investigation H5055194 was found to be substantiated at F312. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 only a suggestion 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 me.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-969

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00276	A. BUILDING: _____ B. WING _____	04/29/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On April 25, 26, 27, 28, and 29, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and mail or email to: Minnesota Department of Health, Health Regulation Division, Licensing and Certification P.O. Box 64900, St. Paul, Minnesota 55164-0900. In addition to the state licensing survey, the following complaints were investigated: - An investigation of complaint H5055194 was substantiated at MN Rule 4658.0525 Subp. 6B. (0920) - Investigation of complaints H5055191, H5055193, H5055187, H5055192 were also conducted and were found to be unsubstantiated. 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 out of compliance is listed in the	2 000		

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2 000	Continued From page 2 "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plans were followed for 1 of 1 residents (R335) reviewed for accommodation of needs and 3 of 5 residents (R69, R336, R18) reviewed for activities of daily living (ADL's). Findings include:	2 565	Corrected.	6/8/16

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2 565	Continued From page 3 R335's care plan dated 1/21/14, indicated R335 had macular degeneration, blind in left eye and was at risk for falls. Intervention for staff to provide R335 included be sure call light is within reach at all times when in room, encourage to use and tell resident where call light was placed. R335 required the assistance of one staff for transfers, bed mobility and ambulation. On 4/25/16, at 3:22 p.m. R335 was sitting in her wheelchair (w/c) alone in her room watching the television. The left side of R335 bed was pushed against the wall. R335's call light was out of reach, hanging down from the call light system located on the wall approximately 18 inches above R335 bed. R335 said "The call light is never in reach it's always in that position along the wall where I can't reach it." On 4/26/16 at 9:59 a.m. R335 call light again was observed to be out of reach. If she needed help, R335 said " I guess I would have to wait until some comes along." Later that day at 4:15 p.m. family member (FM)-A said, "My mother's call light was rarely in place for her to use." On 4/27/16, at 9:40 a.m. R335 call light once again was not in reach. R335 was sitting in her w/c alone in her room. The call light was lying on the floor next to her bed. R335 was asked if she could reach her call light R335 replied "No, it's on the floor and I'm in my w/c." During an interview on 4/27/16, at 9:50 a.m. nursing assistance (NA)-C stated she was the person taking care R335 for the day and was familiar with her cares. NA-C verified R335's call light was noted on the floor and R335 would not have been able to reach it if she needed help.	2 565		

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2 565	Continued From page 4 During an interview on 4/27/16, at 10:07 a.m. assistant director of nursing (ADON) explained she expected all resident to have their call light within reach even if that resident can't use it. R69's care plan dated 3/25/14, identified interventions from staff was to assist with 1 for ADL's and to thoroughly wash hands and under nails due to often digging and smearing Bowel Movement (BM). On 4/27/16, at 7:33 a.m. R69 was observed sitting eating her breakfast in the dining room. All of R69's fingernails and cuticles were dirty, imbedded with a dry dark black/brown color substance. Later that day at 1:15 p.m. R69 was siting in the dining room after lunch with her head resting on the table her nails remained dirty. Nursing assistant (NA)-B stated she was going to to bring R69 back to her room to lie down for the afternoon. NA-B placed her in bed and covered her with a blanket. No other cares was provided to R69. On 4/27/16, at 1:39 p.m. registered nurse (RN)-G stated R69 got her nails done almost everyday. RN-G stated the black/brown substance under her fingernails was feces and further went on to explain that R69 had a habit of digging at her buttocks after she had bowel movement (BM). R69's last BM was that morning. At 1:44 p.m. an interview with the assistant director of nursing (ADON) explained due to the behavior, interventions were put in place for staff to change and check R69 every 2 hours and provide nail care. On 4/28/16, at 8:34 a.m. the ADON verified R69's nails were dirty with feces. R336's care plan dated 2/8/16, indicated R336	2 565		

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WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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2 565	Continued From page 5	2 565		

required one staff assist for grooming and licensed nurses to provide toenail and fingernail care each week.

On 4/25/16, at 3:51 p.m. R336 was observed to have long visible white facial hair along the underside of her chin. Her fingernails had a black substance underneath them and were long and jagged. R336 said "I can't tell if I have hair on my chin I can't see it." R336 explained staff would shave her if asked.

On 4/26/16, at 10:24 a.m. family member (FM)-B was visiting and stated R336 had a razor in her bathroom for staff to use. She staff don't shave R336 regularly.

On 4/27/16 at 9:34 a.m. R336 was observed to still have long facial hair along her chin and dirty fingernails.

On 4/27/16 at 9:56 a.m. NA-C stated she regularly took care of R336 and was proving care for her today. NA-C stated she did not see any facial hair on R336's chin while washing her face this morning. Upon looking at R336, NA-C verified seeing facial hair on R336's chin and her nails were dirty. RN-G walked into R336's room and explained R336 did not get her face shaved on a daily basis. At 10:07 a.m. the ADON verified R336's nails were in need of cleaning, cutting and trimming.

R18's care plan, dated 3/29/16, indicated R18 was to be clean and well groomed daily.

R18 was observed on 4/29/16 8:48 a.m. to have long dirty fingernails with heavy dark soil under all fingernails. R18 stated he did not want long fingernails and should have had them cut. RN-D

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2 565	Continued From page 6 verified R18's un-clean and long fingernails at the time of the observation. RN-D stated R18 got a shower on Friday of last week and verified the nails could not have grown that long in one week. The facility's Policy and Procedure titled "Grooming/Hygiene Cares" with a revision date of 12/11/12, indicated residents grooming will be performed with morning and evening cares and as needed. Care include shaving both males and females, fingernails cleaned and manicured. If the resident was diabetic nail care would be performed by a licensed nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced	2 920		6/8/16

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2 920	Continued From page 7 by: Based on observation, interview and document review the facility failed to ensure shaving and nail care were provided for 3 of 5 residents (R69, R336, R18) reviewed for activities of daily living (ADL's) and were dependent on staff for assistance. Findings include: R69 was eating breakfast in the dining room on 4/27/16, at 7:33 a.m. R69's fingernails and cuticles on both hands were imbedded with a dry dark black/brown substance. Later that day at 1:15 p.m. R69 was in the dining room and her fingernails remained soiled. A short time later a nursing assistant (NA)-B explained she was going to assist R69 to lie down for a rest. The resident was then assisted to bed by NA-B, but no other care was provided for R69 at that time. On 4/27/16 at 1:39 p.m. registered nurse (RN)-G stated R69 received nail care almost everyday. RN-G stated the black/brown substance under her fingernails was feces due to the resident's habit of digging in her rectum following a bowel movement (BM). R69's last BM was that morning. On 4/27/16, at 1:44 p.m. the assistant director of nursing (ADON) verified she was aware R69 often had fecal matter under her fingernails due to scratching her buttocks. The ADON explained that interventions had been put into place which included staff to check and change the resident every two hours and provide nail care. When the ADON and surveyor went into R69's room NA-B was still in the room. R69 was scratching her buttocks and reported, "It's itchy." The ADON instructed NA-B to use a wet wipe to clean her fingernails.	2 920	Corrected.	

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2 920	Continued From page 8 R69's Minimum Data Set (MDS) dated 2/15/16, indicated R69 required staff assistance with personal hygiene. R69's care plan dated 3/25/14, identified interventions of staff assist of 1 with ADL's and to thoroughly wash hands and under nails due to often digging and smearing Bowel Movement (BM). A review of R69's Weekly Bath Audit sheet between 10/14/15 and 4/27/16, indicated R69 only received nail care twice on 3/21/16 and 4/27/16 after the ADON was informed of the grossly soiled fingernails. A follow-up interview on 4/28/16, at 8:34 a.m. the ADON verified R69's nails yesterday were soiled with feces. The ADON explained that if a staff member saw a resident with dirty hands and/or fingernails they should offer the wet wipes that are at each dining room table and offer assistance if they need it. The ADON verified she expected her staff to be doing this and no resident should be eating at the table with dirty or soiled hands. R336's physician's orders dated 3/11/16, indicated a diagnoses of Type 2 diabetes mellitus, dementia and Alzheimer's. R336's care plan dated 2/8/16, indicated R336 required one staff assist for grooming and licensed nurses to provide toenail and fingernail care each week. On 4/25/16, at 3:51 p.m. R336 was observed to be unshaven and had long dirty jagged fingernails. R336's had long white facial hair along the underside of her chin. Under her fingernails was a black substance. R336 said "I can't tell if I have hair on my chin I can't see it." R336 explained staff would shave her when	2 920		

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2 920	Continued From page 9 asked. On 4/26/16, at 10:24 a.m. R336's family member (FM)-B was visiting and stated R336 had a razor in her bathroom for staff to use. FM-B didn't know why staff didn't shave her regularly. On 4/27/16 at 9:34 a.m. R336 was observed sitting up in bed eating her breakfast. RN-G came into R336's room to bring her coffee. R336 continued to have the same long facial hair along her chin and dirty fingernails. On 4/27/16 at 9:56 a.m. NA-C stated she regularly took care of R336 and was providing care for her today. NA-C explained after breakfast she took R336 to the bathroom and provided cares. NA-C verified she was done with R336's (ADL's) for the morning. NA-C stated the care provided to R336 included washing her face, combing her hair, incontinent cares if needed and oral cares. NA-C stated she did not see any facial hair on R336's chin while washing her face this morning. When R336 was observed, NA-C verified seeing facial hair on R336's chin and dirty nails. RN-G came into R336's room and explained R336 does not get her face shaved on a daily basis. RN-G asked R336 if she wanted to have her chin hairs shaved. R336 replied "it's fine" then said, "I guess I should mind I do have hair on my face." At 10:07 a.m. NA-C verified she had already provided grooming cares to R336. The ADON verified that R336 nails were in need of cleaning, cutting and trimming. The ADON explained R336 usually got a manicure weekly from the therapeutic recreation (TR) staff where they trim her nails. The ADON reviewed R336's weekly bath audits and identified R336 had not received nail care. The ADON explained on bath days the staff should be providing grooming cares	2 920		

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2 920	Continued From page 10 to all resident which would include shaving and nail cares if needed. The cares should be documented on the bath sheets. On 4/27/16 at 2:01 p.m. therapeutic recreation staff (TR)-A stated she had in the past provided manicures for R336. The last time R336 came to a manicure activity was 3/17/16. TR-A stated R336 had not attended the manicure activity for the last two weeks and didn't remember the last time she trimmed her fingernails. A review of R336 Weekly Bath Audits sheets between 2/8/16 to 4/24/16, indicated R336 received nail care once on 2/8/16. The facility's Policy and Procedure titled "Grooming/Hygiene Cares" revision date 12/11/12, indicated resident grooming will be preformed with morning and evening cares and as needed. Care included shaving both males and females, fingernails cleaned and manicured. If a diabetic resident nail care will be preformed by a licensed nurse. R18's admission Minimum Data Set (MDS) assessment, dated 3/22/16, indicated R18 required extensive assistance with personal hygiene. The care area assessment, related to activities of daily living, indicated to proceed to care plan development in order to provide comfort and dignity for R18. The care plan, dated 3/29/16, indicated R18 was to be clean and well groomed daily. On 4/29/16, at 8:48 a.m. R18 was observed with long, dirty fingernails with heavy dark soil under all nails. The observation was verified by RN-D, at the time of the observation. RN-D explained R18 was on hospice and received 2 baths per week, a	2 920		

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2 920	Continued From page 11 bed bath from hospice staff and shower from the facility staff. RN-D verified R18's bath day was scheduled for Wednesdays and nail care would be a part of regular bathing hygiene and daily hygiene as needed. The electronic health record indicated a bath was to be completed by the facility on Wednesdays. Documentation for completion of a bath was blank for 4/6/16 and 4/13/16. RN-D explained there had been a computer problem that had since been corrected. The documentation on 4/27/16 indicated R18 had refused a bath. RN-D stated R18 got a shower on Friday of last week and verified the nails could not have grown that long in one week. RN verified nail care would be included as part of a bed bath. The facility's Policy and Procedure titled "Grooming/Hygiene Cares" with a revision date of 12/11/12, indicated residents grooming will be performed with morning and evening cares and as needed. Care included shaving both males and females, fingernails cleaned and manicured. If the resident was diabetic, nail care would be performed by a licensed nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents in need of assistance with personal hygine to assure they are receiving the necessary treatment/services to maintain personal hygiene and to promote dignified and proper care. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		

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21015	Continued From page 12	21015		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure safe food handling procedures were followed in the kitchen This had the potential to affect all 289 residents in the facility. Findings include: During a revisit to the kitchen on 4/27/16, at 11:03 a.m. food service worker (FSW)-C, a cook and assistant supervisor, were observed working with bare hands while making multiple grilled cheese sandwiches. Slices of bread and cheese were laid out to be closed up and put in a pan for heating. FSW-C ran out of cheese, and went to the cooler for more. FSW-C grabbed the handle to the cooler door, entered to get the package of sliced cheese, and brought it back to the prep counter. Without stopping for handwashing, FSW-C reopened the plastic-wrapped cheese, peeled slices out of the package, and began laying them on buttered bread slices sitting on the prep counter. When about handwashing FSW-C stated there was no need to, as the handle got wiped down at the start and end of the shift. When asked specifically if hands should be washed when coming back from the cooler to work on food prep FSW-C said "Yes." FSW-C	21015	Corrected.	6/8/16

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21015	Continued From page 13 acknowledged hands had not been washed then stated again, "We wipe the handle of that cooler down at the beginning and end of the shift." The Infection Control Culinary Services policy revised 7/11/12, indicated "Culinary Services Staff Members:..Will practice proper food handling procedures, including but not limited to hand washing..." On 4/27/16 at 11:21 a.m. FSW-D, a kitchen supervisor said, "Yes, I would expect to see handwashing after a kitchen worker goes to the cooler and touches the handle before resuming food handling." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to provision of care and services. The DON or designee, could provide training for all nursing staff related the proper care of residents. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced	21375		6/8/16

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21375	Continued From page 14 by: Based on observation, interview and document review,the facility failed to implement effective infection control procedures during morning cares for 1 of 1 resident (R176) reviewed on clostridium difficile (c-diff) colitis precautions. Findings include: R176's nurse practitioner (NP) visit notes, dated 4/22/16, revealed the following diagnoses: clostridium difficile colitis, recurrent UTI, and pressure ulcers. The NP further noted "Still having loose stools about 2-3 times per day." A form entitled "THIS PATIENT IS ON STRICT ISOLATION" dated 4/12/16, revealed R176 was on isolation precautions for c-diff beginning 4/12/16 and those precautions had not been discontinued. On 4/28/16, at 9:45 a.m. the nurse manager (RN)-F and a nursing assistant, (NA)-A were observed assisting R176 with morning cares in her room. RN-F and NA-A were observed to don shoe covers, gowns and gloves prior to entering the room. RN-F was observed to put lotion on R176's bottom. RN-F then removed her gloves and donned new gloves, without performing hand hygiene, and continued to assist NA-A. NA-A cleaned R176's bottom. Wipes were noted to be red tinged. NA-A reported she needed more incontinence briefs. RN-F reported she would get them. RN-F was then observed to remove her gown, shoe covers and gloves, open the door and leave the room. RN-F did not perform hand hygiene prior to opening the door and leaving room. RN-F was observed to put hand sanitizer gel on her hands at a nearby medication cart. The door knob was not sanitized after completion of	21375	Corrected.	

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cares. RN-F returned to room with disposable briefs and was wearing a gown, gloves and foot covers. RN-F applied cream to R176's bottom. RN-F then removed her gloves, placed the gloves in the garbage. RN-F donned new gloves, without first completing hand hygiene. R176 asked for the phone. RN-F handed her the phone with gloved hands. R176 used the phone. NA-A informed RN-F that R176's catheter bag was full. RN-F obtained a graduated cylinder from the bathroom. No hand hygiene was performed or gloves changed. RN-F emptied the catheter bag into the graduated cylinder without first wiping the spigot clean. RN-F then emptied the cylinder into the toilet, removed her gloves and donned new gloves. No hand hygiene was performed between glove changes. RN-F then assisted NA-A with putting clothes on R176. NA-A identified she needed to swap out mechanical lifts. NA-A removed her gown, shoe covers and gloves, opened the door and left the room without performing hand hygiene. NA-A returned with a mechanical lift and was again wearing a gown, gloves and protective shoe covers. RN-F then straightened out pillows on the bed and assisted NA-A with using the mechanical lift to transfer R176 to the wheelchair. NA-A straightened the linen on the bed while RN-F brushed R176's hair with gloved hands. RN-F did not perform hand hygiene between performing catheter cares and assisting R176 to transfer and brushing her hair. During cares R176 expressed frustration over a cycle of c-diff infections and urinary tract infections. Upon completion of cares, RN-F reported she used hand sanitizer between glove changes and after leaving the room. RN-F was unable to locate the hand sanitizer she used. RN-F reported she used the washcloth to clean the spigot of the catheter. RN-F reported she thought she needed to wash hands only after

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21375	Continued From page 16	21375		

cares were completed and hand sanitizer was ok between glove changes and while briefly leaving the room to get supplies. RN-F reported R176 was on c-diff precautions but she was hoping they could be discontinued soon.

On 4/28/16 at 2:38 p.m. the director of nursing (DON) was informed of the infection control concerns. The DON reported she was unfamiliar with facility policy and procedure as she was newly hired. The DON reported she would expect staff to follow the infection control policies and procedures.

The Hand washing/Hand Hygiene policy, dated 4/20/12, directed staff "Handwashing Indications: A. When providing resident care 1) Before you begin and after any care 2) Between residents in your care 3) Before putting on gloves and after removing them 4) After touching blood or other body substances 5) After touching any potentially contaminated objects such as dressings, catheters, bedpans, basins, clothing or linen, specimen container and so forth"

The Clostridium Difficile Infection policy, last revised 7/27/12, directed staff "Transmission-based precautions 1) C. Diff is shed in feces. a. Any surface, device or material (such as commodes, bathing tubs and electrical rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the C. diff spores. b. C. Diff spores are transferred to patients mainly via hands that have touched a contaminated surface or item. c. Reinforce Standard Precautions with high emphasis on hand washing. 2. Initiate Contact Precautions for all symptomatic and asymptomatic residents when C. Diff is suspected or diagnosed. a. Place these residents in private rooms. If private rooms

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WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 17 are not available, these residents can be cohorted with other residents with C. Diff infection. b. Use gloves when entering resident's room and during resident care. c. Perform hand hygiene after removing gloves. d. Because alcohol does not kill C. Diff. spores, use of soap and water is more efficacious than alcohol-based hand rubs." The Catheter Care-Indwelling policy, last revised 8/1/13, directed staff to "wash hands/perform hand hygiene" and "F. Apply soap to the second washcloth to wash the catheter. G. Wiping downward away from urethral opening, cleanse approximately 2-3 inches of catheter tubing. Firmly grasp the catheter to prevent tugging on it and gently wash the tubing. and "4) Gently dry the tubing." and "remove gloves, wash hands" SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of proper handwashing and prevention of disease transmission. The DON or designee, could coordinate audits to ensure proper hadwashing is performed TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of	21426		6/8/16

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21426	Continued From page 18 Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Mantoux for tuberculosis (TB) screening was given upon admission for 1 of 5 residents (R294), a sign/symptom screening for TB was completed upon admission for 1 of 5 residents (R591), and a Mantoux was read properly upon admission for 1 of 5 residents (R590) reviewed for TB monitoring. Findings include: A review of R591's Mantoux records TB screening was not completed in the admission nursing assessment (boxes were left blank) and R591's Mantoux noted on the medication administration record (MAR) when read on 4/26/16, indicated (-) but did not note the induration in mm (millimeters) as guidelines required.	21426	Corrected.	

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A review of R294's Mantoux records when admitted to the facility on 4/24/16, indicated R294's first Mantoux after admission scheduled to be given on 4/25/16, and had not yet been given as of the morning of 4/28/16.

During interview with registered nurse (RN)-B on 4/28/16, at 9:12 a.m. RN-B stated nurses were trained to write in the induration in mm when reading the residents' Mantoux even if the reading was zero. RN-B stated the facility's practice was to give the first Mantoux to the newly admitted resident within 24 hours. RN-B stated she had not been aware R294 had not yet been given his first Mantoux and verified on the MAR that it was late and that she would be talking to a current nurse working today and have him or her give the Mantoux to R294. RN-B also verified that R590, who had been admitted to the facility 4/22/16, had a Mantoux scheduled to be given on 4/23/16, and had not been given until 4/25/16. RN-B stated the TB screening was to be completed by the nurse upon the resident's admission. RN-B stated while looking at R590 TB screening could not tell if it had been completed as no boxes were checked on the TB screening section in the nursing admission assessment.

At 9:52 a.m. RN-D stated residents' TB screenings were completed upon admission and the first Mantoux was within 48 hours.

A few minutes later RN-E stated TB screenings were completed upon residents' admission in the nursing admission assessment and there were facility standing orders to give the first resident Mantoux.

On 4/28/16, at 11:06 a.m. infection control nurse (IC) stated resident Mantoux were supposed to

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21426	Continued From page 20 be within 72 hours, and were given the first day or two after the resident's admission. IC stated the nurses when reading the resident's Mantoux needed to include the induration in mm and not just the positive or negative reading. IC also stated the nursing managers were to be monitoring the completion of the two step Mantoux and TB screening for the residents. The 2/10/16, policy provided by the facility Tuberculin Skin Test - Resident indicated "All residents must receive a baseline Tuberculosis (TB) screening within 72 hours of admission. TB screening includes an assessment of the resident's risk factors for TB, any current TB symptoms, and a 2-step Mantoux Tuberculin Skin Test (TST), a chest x-ray, or Quantiferon test as indicated." The same facility policy also indicated "Document in millimeters the size of induration only and document whether the results are positive or negative." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to TB testing procedures. The DON or designee, could provide training for all nursing staff related to TB testing. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be	21530		6/8/16

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21530	Continued From page 21 reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the consulting pharmacist's recommendations were acted upon related to orthostatic blood pressure monitoring for 1 of 5 residents on an antipsychotic medication (R535) reviewed for unnecessary medications. Findings include: R535 was admitted to the facility on 2/3/16. R535's initial Minimum Data Set (MDS) dated 2/8/16, indicated the resident was prescribed antipsychotic medication (for psychosis) in the 7-day assessment period for the diagnosis of non-Alzheimer's dementia. The 2/8/16, MDS also indicated R535 was also prescribed antidepressant and anti-anxiety medications. Review of R535's physician orders upon admission dated 4/3/16, indicated R535 had started on an antipsychotic medication Seroquel 12.5 mg (milligrams) twice a day for psychosis. The physician order directed staff to check the orthostatic blood pressures for R535 daily for three days. Review of R535's TAR where orthostatic BP's were recorded indicated the order was not followed. There were no orthostatic BP's. Review of R535's physician orders dated 4/27/16, indicated to correct the diagnosis for medications Midodrine (increases BP) and Fludrocort (steroid) from hypertension to orthostatic hypotension (drop in BP upon rising). The physician order dated 4/28/16, directed staff to take R535's orthostatic BP every month on the 27th.	21530	Corrected.	

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21530	Continued From page 23 Review of the consulting pharmacist (CP) Communication to Nursing identified a nursing recommendation dated 3/8/16, "This resident has an order for antipsychotic med. Guidelines require the following monitoring for this category of meds: ... Monthly or quarterly Ortho-BP" and nursing recommendation dated 4/4/16, "This resident has an order for antipsychotic med. Guidelines require the following monitoring of this category of meds: ... "Monthly or quarterly Ortho-BP" Review of an incident report indicated on 4/9/16, at 5:00 a.m. R535 was found on the floor next to his bed. The incident report stated R535 had been reaching for a blanket on his wheelchair. On 4/27/16, at 9:35 a.m. R535 was observed standing alone in his room near his recliner with his walker. R535 stated he never felt dizzy. At 11:01 a.m. R535 walked down the hall, steady and unassisted with his wheeled walker toward the dining room. At 12:30 p.m. R535 stood by the dining room table with his walker, adjusted his pants and sat down at the table independently. On 4/27/16, at 11:00 a.m. registered nurse (RN)-E stated R535 was not a fall risk. R535 had fallen when he first came to the facility but walked pretty steady. RN-E also verified R535's record did not indicate an orthostatic blood pressure (BP) had been taken for R535 since his admission to the facility. On 4/27/16, at 10:41 a.m. nurse practitioner (NP) stated if a resident was ambulatory and on an antipsychotic medication she recommended orthostatic blood pressures be taken monthly for that resident.	21530		

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21530	Continued From page 24 On 4/27/16, at 12:40 p.m. RN-D stated R535 had diagnoses of progressing Parkinson's and psychosis. R535 had fallen at home and had a couple of falls after admission to the facility but had been doing well lately. RN-D stated R535 was steady on his feet. RN-D stated it was the pharmacist who would tell the facility which residents were to have an orthostatic BP taken. Additionally, an orthostatic BP might be used as a fall intervention. RN-D stated that an orthostatic BP's had not been discussed at the daily meeting when falls were reviewed as a fall intervention for R535. RN-D waited for the CP to make a recommendation. RN-D stated she was not aware of a recommendation from the CP for an orthostatic BP to be taken for R535. RN-D verified on R535's 2/16 treatment administration record (TAR) that the daily orthostatic BP's ordered for 3 days for R535 had not been completed. RN-D also verified the rationale for two medications for blood pressure were incorrectly identified on the medication administration record (MAR) for a diagnosis of hypertension (high BP) rather than orthostatic hypotension (drop in BP with changes in position). RN-D stated she would follow up. On 4/28/16, at 9:50 a.m. RN-D stated she called the NP. The NP had changed the diagnosis back to orthostatic hypotension and ordered monthly orthostatic BP's for R535. RN-D stated an orthostatic BP was taken last evening for R535. RN-D stated there was a 18 point drop in R535's systolic (the top number) BP. RN-D stated nurses were supposed to report to the physician or NP a drop of 10 points or more in the BP. On 4/28/16, at 9:55 a.m. RN-E stated nothing had been passed on in early morning report about a drop in systolic BP for R535. There was also	21530		

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nothing on the 24 hour report board about it. RN-D then stated there was no progress note nor evidence of any call to the NP or physician regarding the drop in BP for R535. RN-D stated she would follow up with it.

On 4/28/16, at 10:03 a.m. on 4/28/16, RN-E stated she would not call the NP or physician related to a BP issue unless there were parameters set to call them. RN-E stated she was not aware of R535's diagnosis of orthostatic hypotension or of R535's previous falls at home. RN-E stated R535 was a fall risk in at admission but R535 had not had any falls in a long time. RN-E stated R535 was now stable on his feet as long as he walked with his walker. RN-E stated R535 was independent with transfers and ambulation.

On 4/28/16, at 10:09 a.m. licensed practical nurse (LPN)-A stated she would call the NP or physician if a resident's BP dropped 8 points or more and would chart it in a progress note. LPN-A stated R535 had hypotension (low BP), and that R535's BP's did not run high because of the medications he took.

On 4/28/16, at 10:24 a.m. LPN-B stated she would call the NP or physician if the systolic BP was less than 100 or if there were NP or physician ordered parameters. LPN-B stated it "depended on what the resident's baseline BP was."

On 4/28/16, at 12:09 p.m. the CP said he came to the facility every month to review residents' medications. The CP stated on the 3/8/16 visit, he made a recommendation to the facility for monthly or quarterly orthostatic BP's to be taken for R535. The CP stated nurses can make a

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21530	Continued From page 26 clinical judgement on how often to take the orthostatic BP's. The CP stated the facility usually asked the NP how often to take them and the NP would write the order. The CP stated he had seen the order the NP had written upon admission for R535 in early February for orthostatic BP's to be taken daily for 3 days. The CP identified the orthostatic BP's ordered had not been done. The CP stated he made the BP recommendation in 3/16. The CP also stated he had emailed the interim director of nursing (IDON) on 4/5/16, that R535 needed an orthostatic BP's taken. The CP stated a NP or physician should be informed of a 10-20 point drop in systolic BP during an orthostatic BP. On 4/28/16, at 1:35 p.m. the IDON stated she had been the IDON since mid January and now as of a few days ago was the assistant director of nursing (ADON). The ADON stated the CP came to the facility once a month to review all the residents' medications. The ADON stated the CP typically mailed the recommendations to her within 3 days of his visit and she gave the hard copy of the recommendation to each nurse manager by the next business day. The ADON stated the CP had been at the facility on 4/5/16. The ADON stated she expected the nurse manager to schedule the orthostatic BP on the TAR and to follow up to make sure it was done. The ADON also stated upon receiving the nursing recommendation she would expect the nurse manager to clarify with either the NP or the CP which time frame (monthly or quarterly) would be appropriate for the resident. The ADON stated the NP made the decision. The ADON stated the nurse would have to notify the NP if there was a significant change in the BP when taking an orthostatic BP. The facility did not follow a specific guideline of when to call the practitioner.	21530		

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21530	Continued From page 27 The ADON stated she would have contacted the NP on R535's 18 point drop in systolic BP because of his needs. He had a diagnosis of orthostatic hypotension and was on an antipsychotic medication. The ADON stated falls were discussed daily at standup, the nurse managers put the fall interventions in place and she was not aware of any discussions regarding R535's blood pressure. The policy provided by the facility dated 10/22/13, Monthly Medication Review indicated "The MRR (medication regimen review) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician. Recommendations are acted upon and documented by the facility staff and/or the prescriber. The director of nursing or designated licensed nurse will address and document recommendations that do not require physician intervention (e.g., Vital sign monitoring, labs, PRN documentation.)." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		

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21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide orthostatic blood pressure monitoring for 1 of 5 residents on an antipsychotic medication (R535) and reviewed for unnecessary medications. Findings include: R535 was admitted to the facility on 2/3/16. R535's initial Minimum Data Set (MDS) dated 2/8/16, indicated the resident was prescribed	21540	Corrected.	6/8/16

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21540	Continued From page 29 antipsychotic medication (for psychosis) in the 7-day assessment period for the diagnosis of non-Alzheimer's dementia. The 2/8/16, MDS also indicated R535 was also prescribed antidepressant and anti-anxiety medications. Review of R535's physician orders upon admission dated 4/3/16, indicated R535 had started on an antipsychotic medication Seroquel 12.5 mg (milligrams) twice a day for psychosis. The physician order directed staff to check the orthostatic blood pressures for R535 daily for three days. Review of R535's TAR where orthostatic BP's were recorded indicated the order was not followed. There were no orthostatic BP's. Review of R535's physician orders dated 4/27/16, indicated to correct the diagnosis for medications Midodrine (increases BP) and Fludrocort (steroid) from hypertension to orthostatic hypotension (drop in BP upon rising). The physician order dated 4/28/16, directed staff to take R535's orthostatic BP every month on the 27th. Review of the consulting pharmacist (CP) Communication to Nursing identified a nursing recommendation dated 3/8/16, "This resident has an order for antipsychotic med. Guidelines require the following monitoring for this category of meds: ... Monthly or quarterly Ortho-BP" and nursing recommendation dated 4/4/16, "This resident has an order for antipsychotic med. Guidelines require the following monitoring of this category of meds: ... "Monthly or quarterly Ortho-BP" Review of an incident report indicated on 4/9/16, at 5:00 a.m. R535 was found on the floor next to his bed. The incident report stated R535 had	21540		

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21540	Continued From page 30 been reaching for a blanket on his wheelchair. On 4/27/16, at 9:35 a.m. R535 was observed standing alone in his room near his recliner with his walker. R535 stated he never felt dizzy. On 4/27/16, at 11:00 a.m. registered nurse (RN)-E verified R535's record did not indicate an orthostatic blood pressure (BP) had been taken for R535 since his admission to the facility. On 4/27/16, at 10:41 a.m. nurse practitioner (NP) stated if a resident was ambulatory and on an antipsychotic medication she recommended orthostatic blood pressures be taken monthly for that resident. On 4/27/16, at 12:40 p.m. RN-D stated R535 had diagnoses of progressing Parkinson's and psychosis. R535 had fallen at home and had a couple of falls after admission to the facility but had been doing well lately. RN-D stated it was the pharmacist who would tell the facility which residents were to have an orthostatic BP taken. RN-D stated that an orthostatic BP's had not been discussed at the daily meeting when falls were reviewed as a fall intervention for R535. RN-D waited for the CP to make a recommendation. RN-D verified on R535's 2/16, treatment administration record (TAR) the daily orthostatic BP's ordered for 3 days had not been completed. RN-D stated she would follow up. On 4/28/16, at 9:50 a.m. RN-D stated she called the NP. The NP had ordered monthly orthostatic BP's for R535. RN-D stated an orthostatic BP was taken last evening for R535. RN-D stated there was a 18 point drop in R535's systolic (the top number) BP. RN-D stated nurses were supposed to report to the physician or NP a drop	21540		

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21540	Continued From page 31 of 10 points or more in the BP. On 4/28/16, at 9:55 a.m. RN-E stated nothing had been passed on in early morning report about a drop in systolic BP for R535. There was also nothing on the 24 hour report board about it. RN-D then stated there was no progress note nor evidence of any call to the NP or physician regarding the drop in BP for R535. RN-D stated she would follow up with it. On 4/28/16, at 10:03 a.m. on 4/28/16, RN-E stated she would not call the NP or physician related to a BP issue unless there were parameters set to call them. RN-E stated she was not aware of R535's diagnosis of orthostatic hypotension or of R535's previous falls at home. RN-E stated R535 was a fall risk in at admission but R535 had not had any falls in a long time. On 4/28/16, at 10:09 a.m. licensed practical nurse (LPN)-A stated she would call the NP or physician if a resident's BP dropped 8 points or more and would chart it in a progress note. LPN-A stated R535 had hypotension (low BP), and that R535's BP's did not run high because of the medications he took. On 4/28/16, at 10:24 a.m. LPN-B stated she would call the NP or physician if the systolic BP was less than 100 or if there were NP or physician ordered parameters. LPN-B stated it "depended on what the resident's baseline BP was." On 4/28/16, at 12:09 p.m. the CP said he came to the facility every month to review residents' medications. The CP stated on the 3/8/16 visit, he made a recommendation to the facility for monthly or quarterly orthostatic BP's to be taken	21540		

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21540	Continued From page 32 for R535. The CP stated nurses can make a clinical judgement on how often to take the orthostatic BP's. The CP stated the facility usually asked the NP how often to take them and the NP would write the order. The CP stated he had seen the order the NP had written upon admission for R535 in early February for orthostatic BP's to be taken daily for 3 days. The CP identified the orthostatic BP's ordered had not been done. The CP stated he made the BP recommendation in 3/16. The CP also stated he had emailed the interim director of nursing (IDON) on 4/5/16, that R535 needed an orthostatic BP's taken. The CP stated a NP or physician should be informed of a 10-20 point drop in systolic BP during an orthostatic BP. On 4/28/16, at 1:35 p.m. the assistant director of nursing (ADON) stated she expected the nurse manager to schedule the orthostatic BP on the TAR and to follow up to make sure it was done. The ADON also stated upon receiving the nursing recommendation she would expect the nurse manager to clarify with either the NP or the CP which time frame (monthly or quarterly) would be appropriate for the resident. The ADON stated the NP made the decision. The ADON stated the nurse would have to notify the NP if there was a significant change in the BP when taking an orthostatic BP. The facility did not follow a specific guideline of when to call the practitioner. The ADON stated she would have contacted the NP on R535's 18 point drop in systolic BP because of his needs. He had a diagnosis of orthostatic hypotension and was on an antipsychotic medication. The ADON stated falls were discussed daily at standup, the nurse managers put the fall interventions in place and she was not aware of any discussions regarding R535's blood pressure.	21540		

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21540	Continued From page 33 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair	21670		6/8/16

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21670	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation and interviews the facility failed to ensure bed linens were clean and/or in good repair for 3 of 3 residents observed (R69, R425, R439) and to ensure the clean linens stored for use were in good repair. This had the potential to affect all residents who utilized the linens. Findings include: On 4/27/16, at 1:15 p.m. R69 was siting in the dining room after lunch with her head resting on the table. A nursing assistant (NA)-B stated she was going to to bring R69 to her room to lie down for the afternoon. NA-B stated R69 required the assistance of two staff with the use of a hoyer lift (a mechanical full body lift). R69 was placed in bed and NA-B covered her with a blanket. There was a large brown circular stain approximately 6 inches round on top of the bed blanket. At 1:39 p.m. registered nurse (RN)-G stated R69 had the behavior of digging at her buttocks after she has had a bowel movement (BM). The ADON stated staff was aware of R69's behavior of digging and smearing feces. During the environmental tour on 4/28/16, at 9:05 a.m. the following staff was present, maintenance supervisor (MS), director of nursing (DON) and housekeeper/laundry supervisor (HS/LS). The following was noted: 1. R69's bed was observed to be made, the sheets tucked in, the top blanket was pulled up and R69's pillow was neatly placed at the head of the bed. However during the tour, R69's top bed	21670	Corrected.	

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21670	Continued From page 35 blanket still contained the same stained observed on 4/27/16. When the sheets were pulled back the fitted sheet was visually worn and stained. R69's pillow was turned over and a brown substance was noted on the back side of her pillow case. 2. R425's fitted sheet was very thin and had visible wear marks. 3. R439's fitted sheet was so thin the mattress could be seen though it when held up. 4. 7 Gamble's clean linen closet had one fitted sheet that was worn with a hole in it and two fitted sheets that had dried on sticky food. 5. 4 Rain's clean linen closet contained fitted sheets that were worn and had holes. The three staff present during the tour verified the linens were not in good condition and should not have been placed on resident's beds or in the clean linen rooms. All staff stated their expectations were if staff observed dirty bed linens or in bad condition they should be replaced and/or thrown away. The HS/LS verified the clean linen closets on 4 Rains and 7 Gamble had sheets that were not in good condition. HS/LS declined to look through other clean linen closets in the facility and stated there was a system problem with nursing and laundry staff. On 4/29/16, at 8:26 a.m. the laundry room was toured with the HS/LS. Laundry aide (LA)-A was folding clean linen and explained if any laundry items were thin or had holes in them they were thrown away and "we never bring up dirty linens." The HS/LS went to a laundry cart ready for the floor. Fitted sheets were pulled from the clean	21670		

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21670	Continued From page 36 cart still warm from the dryer. The HS/LS sorted through the sheets one by one. As he got to a sheet that was too thin, had a hole or a stain he tossed it to LA-A and informed LA-A they were not to be used. Within a short period of time, more than 15 fitted sheets were thrown away. The HS/LS explained they had recently changed vendors and the sheets that are worn were from the old vender. He verified the sheets were thin, not in good condition and needed to be replaced. The facility's policy titled "Linens-Clean" dated 7/17/20, indicated "clean laundry/bedding is to be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen." Although requested, no policy related to linen replacement was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21670		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest	21730		6/8/16

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21730	Continued From page 37 control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents room doors were in good repair. In addition the facility failed to ensure ceiling lights were free from insects (ladybugs). This had the potential to affect multiple residents on 2 units (1 Rains, 6 Gamble). Findings include: During multiple resident interviews on 4/25/16 and 4/26/16, with R165, R293, R318 and R335 it was observed all the resident ceiling lights had many dead ladybugs in them. On 4/25/16, at 7:09 p.m. R165 stated to the surveyor "I wish you could do something about all these bugs," as she pointed to some live ladybugs crawling on her floor under her bedside tray table. R165 explained there is an infestation of bugs "the other day behind by the video stand was a pile of dead ladybugs on the floor." R165 said, "I feel it's a cleanliness thing more than anything." During the environmental tour on 4/28/16, at 9:05 a.m. the following staff was present, maintenance supervisor (MS), director of nursing (DON) and housekeeper/laundry supervisor (HS/LS). The following was noted: 1. Multiple ceiling lights leading to the dining room on 1 Rains contained many dead ladybugs in the ceiling lights.	21730	Corrected.	

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21730	Continued From page 38 2. 2/3 of one of the ceiling lights in the dining room on 1 Rains contained live and dead ladybugs crawling along inside the ceiling light fixture where residents eat their meals. 3. Resident (R165, R293, R318, R335) ceiling lights had dead ladybugs in them. 4. Resident (R15, R17, R235, R300, R438, R535) doors on the floors 4, 5, and 7 Gamble had long scratch marks that went along the bottom 2/3 of the door. There were nicks and large gouges of wood missing from the doors. 5. R235's bathroom door was scratched up and missing approximately half the paint. 6. R438 stated "This door has been like this since I moved in [1/27/15] I go straight in/out and do not hit the door." The door was observed to have multiple scratches the length of her door with 3 large gouges on the side of her door. The three staff present during the tour verified the live and dead bugs in the ceiling light fixtures were ladybugs. All three staff presents verified residents should not have to look up while eating or in their rooms and see dead bugs. The HS/LS explained he was aware of the ladybug issues throughout the facility. HS/LS verified the facility pest control company did not have any solution to control the ladybugs other than his staff vacuuming them up when needed. HS/LS verified that dining room ceiling light on 1 Rains should have been taken care of right away. The three staff present during the tour verified the doors were not in good conditions and were in need of repairs. The MS explained if staff or nursing saw an issue they would fill out a work	21730		

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21730	Continued From page 39	21730		

order either on line, paper form or let the front desk know. Maintenance staff was informed of the concern. The MS stated he did have a preventive maintenance plan but it was more related to cleaning the vents, monitoring fire drills and more mechanical type items. The HS/LS explained any doors with deep gouges would be taken off and sanded down. The MS stated he had not received any request for doors in need of repair. The MS explained his staff watched for things that needed repair, "we do a facility walk through of a couple of floors a week." The MS further indicated there had been a sheet of which floors were toured and what things needed repair but that was no longer done. The MS could not identify the last time he or his staff did a walk through nor which floors were done.

A review of the facility's pest control book from Adams pest control, Inc. indicated under "Customer pest sighting," on 10/13/15, 4/21/16 and 4/26/16 ladybugs were seen on 4 gamble and the conference room by the dental office. The service date by Adams pest control Inc. was 11/9/15, and indicated action taken was exterior treatment, recommend using vacuum for interior units and common area.

The facility did not have a policy or procedure for internal pest control.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of maitaining an effective pest control program. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure pests and pest debris is controlled to ensure a clean, functional and homelike

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21730	Continued From page 40 environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		6/8/16

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21800	Continued From page 41 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice in a timely manner prior to the termination of Medicare skilled services for 2 of 3 residents (R247, R493) reviewed for liability notice and beneficiary appeal rights. Findings include: During review of facility liability notice and beneficiary appeal rights for R247 and R493 on 4/27/16, the following was noted: R247's medical record was reviewed for the Notice of Medicare Provider Non-Coverage forms (NMPNC) on 4/27/16. The medical lacked the forms NMPNC that were to be signed by recipients at least 48 hours prior to the end of their Medicare coverage in the facility. However the social service discharge and recapitulation summary dated 12/6/15 read, "resident received PT, OT and speech therapies along with skilled nursing services. Resident to discharge home with home PT and OT therapies." On 4/27/16, at 7:33 a.m. registered nurse (RN)-A stated, the Skilled Nursing Facility Advance Beneficiary Notice and the Notice of Medicare Non-Coverage should be given at least two days before covered services would end. RN-A stated R247 was discharge prior to the 90 days and voluntarily wanted to go home on day 89 and R247 was on and off therapy. In addition, RN-A mentioned, "I did not give the liability and appeal rights notice because of that. Otherwise, I would have given the 48 hours notices." R493's medical record review for the NMPNC on	21800	Corrected.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21800	Continued From page 42 4/27/16, revealed the record lacked the forms that were to be signed by recipients at least 48 hours prior to the end of their Medicare coverage in the facility. However the social service discharge and recapitulation summary dated 12/3/15, read "Date discharge order received: 12/3/15. Community resources/addition information: Resident to d/c [discharge] to Augustina ALF [assisted living facility] with support." On 4/27/16, at 7:37 a.m. RN-A stated the Skilled Nursing Facility Advance Beneficiary Notice and the Notice of Medicare Non-Coverage should be given at least two days before covered services would end. R493 was admitted to the facility for 17 days and discharged choosing to go to an assisted living. Furthermore, RN-A declared, "I did not give the liability and appeal rights notice because of that. Otherwise, I would have given the notice within the 48 hours window." On 4/27/16 at 11:18 a.m. RN-A confirmed, the medical record lacked Skilled Nursing Facility Advance Beneficiary Notice and the Notice of Medicare Non-Coverage for R247 and R493 and stated the resident would have remained skilled until a denial letter was issued. RN-A further stated her expectation was a letter was to be issued to the resident within 48 hours of anticipating no daily skilled services. On 4/27/16 at 11:26 a.m. the rehabilitation (rehab) director verified, the rehab medical records for for R247 and R493 lacked requests to be discharged. The director added, "We do a discharge planning meeting with resident and family as needed and give a 48 hour notice to the Medicare nurse and the rest of the IDT [interdisciplinary team] prior to discharge. In	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00276	A. BUILDING: _____ B. WING _____	04/29/2016

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21800	Continued From page 43 absence of formal meetings, resident and family are notified by the therapist." A facility policy and procedure titled NOTICE OF MEDICARE/MEDICAID BENEFITS dated 2014, read, "Individuals receiving Medicare benefits are re-evaluated on a regular basis by the facility's Medicare coordinator to determine continued coverage based on the daily skilled need. If and when it is determined the resident no longer requires a Medicare skilled service, the facility will notify the resident or responsible party at least 48 hours prior to the change in payer source. If the resident or financially responsible party does not agree with this decision, you will be given the option at that time to request a demand bill. This process will be explained in full at the time of the denial of Medicare benefits." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to provision of notice when skilled services have ended. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning.	21810		6/8/16

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21810	Continued From page 44 This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure call lights were placed within reach for 1 of 1 resident (R335). Findings include: R335 was observed on 4/25/16, at 3:22 p.m. The resident was seated in a wheelchair. One side of the bed was pushed up against the wall. R335's call light was out of her reach and hung down from the call light box approximately 18 inches above the bed. R335 reported, "The call light is never in reach. It's always in that position along the wall where I can't reach it." R335 explained if she needed help she would have to yell for staff to come. On 4/26/16, at 9:59 a.m. R335's call light again was out of her reach as it was clipped to the call light box where the bed was pushed up against the wall. R335 said, "I guess I would have to wait until someone comes along [to get help]." R335 then requested "please clip the call light to the bed" so she could reach it. At 4:15 p.m. R335's family member (FM)-A was visiting the resident and stated, "My mother's call light is rarely in place for her to use." On 4/27/16, at 9:40 a.m. R335's call light was observed out of her reach. R335 was seated in her wheelchair. The call light was lying on the floor next to the bed. When asked if she was able to reach the call light she replied, "No. It's on the	21810	Corrected.	

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21810	Continued From page 45 floor and I'm in my wheelchair." R335's care plan dated 1/21/14, indicated R335 had macular degeneration causing blindness in one eye, and the resident was at risk for falls. Staff was directed to ensure R335's call light was within her reach at all times, inform the resident where to find the light, and to encourage the resident to use the light to call for help. The care plan noted the resident required staff assistance with transfers, bed mobility, and ambulation. On 4/27/16, at 9:50 a.m. nursing assistant (NA)-C reported she was assigned to care for R335 for the day, and was familiar with the her care requirements. NA-C verified R335's call light was noted on the floor and she would not have been able to reach it should she need to summon help. On 4/27/16, at 10:07 a.m. the assistant director of nursing (ADON) explained she expected all residents would have their call lights within reach, even if the resident was unable to utilize the light. In addition, the ADON explained staff should ensure call lights were within the residents' reach at all times. A policy on call light was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe environment. The DON or designee, could coordinate with staff to conduct periodic audits of areas residents frequent to ensure a call lights are within reach. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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