DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: I69L
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00276
1. MEDICARE/MEDICAID PROVID (L1) 245055		3. NAME AND AI (L3) WALKER M	AETHODIST H	HEALTH (CENTER	 TYPE OF ACTION: <u>7</u> (L8) Initial 2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 202742900	NO.	(L4) 3737 BRYA (L5) MINNEAPC		OUTH	(L6) 55409	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>03</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 06/28. ACCREDITATION STATUS:	22/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 0 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited1 TJC2 AOA3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	02/28
11LTC PERIOD OF CERTIFICATIO	DN	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
		· ·			3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	330 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	· _
13.Total Certified Beds	330 (L17)	B. Not in Comp	liance with Progra	am	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied V	Vaivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
308	22					
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Douglas Stevens, HFE	NEII	0	06/28/2016	(L19)	Mark meath	, Enforcement Specialist 08/09/2016 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	OFFICE OR SINGLE S	. ,
19. DETERMINATION OF ELIGIBI	ILITY		IPLIANCE WITH	I CIVIL		ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to	Participate	KIGI	HTS ACT:		 Ownership/Contro Both of the Above 	I Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligib	le (L21)					
22. ORIGINAL DATE	23. LTC AGREED	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 01/01/1967	BEGINNING	G DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	NOF APPROVAL	DATE		
		06/13/2016		_		
	(L32)			(L33)	DETERMINATION APPE	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 169L PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00276

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..



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

An equal opportunity employer.



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 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,

Mart meeth

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245055 _{Y1}	B. Wing	Y2	6/22/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER METHODIST HEALTH C	ENTER	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).

ITE	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix Reg. #	F0156 483.10(b)(5) - (10 483.10(b)(1))),	Correction Completed	ID Prefix Reg. #	F0246 483.15(e)(1)	Correction Completed	ID Prefix Reg. #	F0254 483.15(h)(3)		Correction 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(I)		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 Reg. # LSC	F0441 483.65		Correction Completed 06/08/2016	ID Prefix Reg. # LSC	F0465 483.70(h)	Correction Completed 06/08/2016	ID Prefix Reg. # LSC			Correction Completed
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
REVIEWE STATE AG		REVIEWEI (INITIALS)	D BY GL/mm	date 06/28/2	016	SIGNATURE OF SU	IRVEYOR 3297	76		DATE 06/22	2/2016
REVIEWE CMS RO	D BY	REVIEWEI (INITIALS)		DATE		TITLE				DATE	
FOLLOW	JP TO SURVEY CO	OMPLETED	ON			ANY UNCORRECTE ED DEFICIENCIES (6 🗌 NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - BUILDING 01			
245055 _{Y1}	B. Wing	Y2	6/17/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER METHODIST HEALTH C	ENTER	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).

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ITE	м	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	 NFPA 101	Correction	ID Prefix	 NFPA 1	01	Correction	ID Prefix	 NFPA 101		Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			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 1	01	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 1	01	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			
REVIEWE STATE AG		reviewed by (initials) TL/mm	DATE 06/28/20	016	SIGNATURE OF SU	JRVEYOR 37009			DATE 06/17	/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW	JP TO SURVEY CO	DMPLETED ON			ANY UNCORRECTE					6 🗌 NO

169L22



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

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVI	SIT
	B. Wing	, N	Y2	6/22/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKER METHODIST HEALT	H 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).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20565		Correction	ID Prefix	20920		Correction	ID Prefix	21015		Correction
Reg. #	MN Rule 4658.0 Subp. 3	0405	Completed	Reg. #	MN Ru Subp. 6	le 4658.0525 6 B	Completed	Reg. #	MN Rule 4658.06 Subp. 7	10	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 4658.0 Subp. 1	0800	Completed	Reg. #	MN St. Subd. 3	Statute 144A.04	Completed	Reg. #	MN Rule 4658.13 A.B.C	10	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. Subp. 2	1315	Completed	Reg. #	MN Ru A.B.C.I	le 4658.1405 D.	Completed	Reg. #	MN Rule 4658.14 Subp. 11	15	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. Statute1 Subd. 4	44.651	Completed	Reg. #	MN St. Subd. 6	Statute 144.651 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			
REVIEW STATE A		REVIEW (INITIAL	/ED BY . S) GL/mm	DATE 06/28/2	016	SIGNATURE OF	SURVEYOR 32976			DATE 06/22	/2016
REVIEW CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOW 4/29/201	/UP TO SURVE	Y COMPL	ETED ON			R ANY UNCORREC					s 🗌 no

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MED	ICARE & MEDICAID SERVICES	5
	MEDICA	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: 169L	
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00276	
1. MEDICARE/MEDICAID PROVIDE (L1) 245055	ER NO.	3. NAME AND AI (L3) WALKER N			CENTER	 4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 	
2.STATE VENDOR OR MEDICAID N (L2) 202742900	NO.	(L4) 3737 BRYA (L5) MINNEAPC		OUTH	(L6) 55409	3. Termination4. CHOW5. Validation6. Complaint	
5. EFFECTIVE DATE CHANGE OF ((L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>03</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint 	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	0/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 02/28	
2 AOA 3 Other 11LTC PERIOD OF CERTIFICATION	T	10.THE FACILITY		45.			
From (a):	N	A. In Complia		A5.	And/Or Approved Waivers Of J	The Following Requirements:	
To (b):		Program Ro	equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	 6. Scope of Services Limit 7. Medical Director 	
		1. A	cceptable POC		4. 7-Day RN (Rural SN		
12.Total Facility Beds 13.Total Certified Beds	330 (L18)330 (L17)	X B. Not in Con	npliance with Prog	gram	5. Life Safety Code	9. Beds/Room	
		Requirements	and/or Applied V	Waivers:	* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
308 (L37) (L38)	22 (L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	AKKS (IF APPLICA	ABLE SHOW LIC CA	ANCELLATION I	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Lisa Hakanson, HFE NEI		0	6/01/2016	(L19)	Mark Meath,	Enforcement Specialist 06/10/2016	(L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	OFFICE OR SINGLE ST	FATE AGENCY	()
19. DETERMINATION OF ELIGIBIL	JTY		IPLIANCE WITH	H CIVIL	21. 1. Statement of Finan		
X 1. Facility is Eligible to P	Participate	RIGI	ITS ACT:		 Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION 01/01/1967	BEGINNINC	6 DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change	
(L27)	B. Rescind Su	uspension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APPR	ROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICARE/MEDICAID CERTIFICATIO

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: I69L Facility ID: 00276

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5055

On April 29, 2016 a recertification survey was completed at Walker Methodist Health Center to verify 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 investigations 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.



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:

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

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

Walker Methodist Health Center May 13, 2016 Page 2

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

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

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

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

DEPARTMENT CONTACT

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

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

Walker Methodist Health Center May 13, 2016 Page 4 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

Walker Methodist Health Center May 13, 2016 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Walker Methodist Health Center May 13, 2016 Page 6

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245055	B. WING	i		04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER		-	737 BRYANT AVENUE SOUTH		
			1	N	MINNEAPOLIS, MN 55409		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F	000			
F 156 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has beer your verification. In addition to the re complaints were inv An investigation of substantiated at a D Additionally, complat H5055187, H50551 were unsubstantiate 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf and in writing in a la understands of his regulations governi responsibilities duri facility must also pr notice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Re	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with ecertification survey, vestigated. complaint H5055194 was D for F312. aints H5055191, H5055193, 192 were investigated and	F -	156			6/8/16
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 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.

PRINTED: 06/01/2016

	-	AND HUMAN SERVICES			FORM	06/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245055	B. WING		04/;	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	R METHODIST HEALT	HCENTER	_	8737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	Continued From pa writing.	.ge 1	F 156			
	entitled to Medicaid of admission to the resident becomes a items and services facility services und which the resident r other items and ser and for which the re- the amount of charg inform each resider the items and servic (i)(A) and (B) of this The facility must inf	form each resident before, or				
	at the time of admis the resident's stay, facility and of charg including any charg under Medicare or b	ssion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate.				
	legal rights which in A description of the	rnish a written description of ncludes: manner of protecting personal raph (c) of this section;				
	for establishing elig the right to request 1924(c) which deter non-exempt resource institutionalization a spouse an equitable cannot be consider toward the cost of the	e requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending				

		ARECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED 245055 B. WING 04/29/2016 DEER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MM 55049 WINMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVDERTS PLAN OF CORRECTION (CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETED 00/29/2016 thinued From page 2 wn to Medicaid eligibility levels. D DEFICIENCY) PROVDERTS PLAN OF CORRECTION (CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETED DATE thinued From page 2 wn to Medicaid eligibility levels. F 156 F 156 osting of names, addresses, and telephone holers of all pertinent State Client advocacy ups such as the State survey and certification nocy oncerning resident abuse, neglect, and appropriation of resident applect, and appropriation of resident abuse, neglect, and appropriation of resident sand liver and Medicaid benefits, and how to eiver endures for previous payments covered by in benefits. "R247 and R493 have since discharged from the facility." "All residents will be provided with a					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DATE	E SURVEY
		245055	B. WING			04/;	29/2016
NAME OF F	PROVIDER OR SUPPLIER						
WALKER	R METHODIST HEALT	H CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETION
F 156	Continued From pa down to Medicaid e A posting of names numbers of all perti groups such as the agency, the State lie ombudsman progra advocacy network, unit; and a stateme complaint with the S agency concerning misappropriation of facility, and non-cor directives requireme The facility must inf name, specialty, an physician responsite The facility must pro- written information, applicants for admis information about h Medicare and Medi receive refunds for such benefits. This REQUIREMEN by: Based on interview facility failed to prov- rights notice in a tim termination of Medi	ge 2 ligibility levels. , addresses, and telephone nent State client advocacy State survey and certification censure office, the State am, the protection and and the Medicaid fraud control nt that the resident may file a State survey and certification resident abuse, neglect, and resident property in the mpliance with the advance ents. orm each resident of the d way of contacting the ble for his or her care. ominently display in the facility and provide to residents and ssion oral and written ow to apply for and use caid benefits, and how to previous payments covered by NT is not met as evidenced v and document review, the vide proper liability and appeal hely manner prior to the care skilled services for 2 of 3 493) reviewed for liability	F 1	56	"R247 and R493 have since discha from the facility. "All residents will be provided with a proper liability and appeal rights not a timely manner prior to termination Medicare skilled services.	arged a tice in n of	
	Findings include:				"The Medicare RNs have been edu on the requirement to provide prope		

Facility ID: 00276

PRINTED: 06/01/2016

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY
		245055	B. WING _		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
WALKEF	R METHODIST HEALT	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 156	beneficiary appeal 4/27/16, the followi R247's medical rec Notice of Medicare (NMPNC) on 4/27/ forms NMPNC that recipients at least 4 their Medicare cow the social service of summary dated 12 PT, OT and speec nursing services. F with home PT and On 4/27/16, at 7:33 stated, the Skilled Beneficiary Notice Non-Coverage sho before covered ser R247 was discharg voluntarily wanted R247 was on and of mentioned, "I did n rights notice becau have given the 48 R493's medical rec 4/27/16, revealed t that were to be sig hours prior to the e in the facility. How discharge and reca 12/3/15, read "Date	acility liability notice and rights for R247 and R493 on ing was noted: cord was reviewed for the Provider Non-Coverage forms 16. The medical lacked the twere to be signed by 48 hours prior to the end of erage in the facility. However discharge and recapitulation /6/15 read, "resident received h therapies along with skilled Resident to discharge home OT therapies." 8 a.m. registered nurse (RN)-A Nursing Facility Advance and the Notice of Medicare build be given at least two days vices would end. RN-A stated ge prior to the 90 days and to go home on day 89 and off therapy. In addition, RN-A ot give the liability and appeal use of that. Otherwise, I would hours notices."	F 15	 liability and appeal rights notice manner prior to termination of I "Monitoring to ensure complian conducted by the Administrator designee through the monthly I Audits. "The facility QAPI committee w the status of the Medicare audi further recommendations. 	Medicare. ce will be or Medicare ill review	

Facility ID: 00276

If continuation sheet Page 4 of 42

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTI A. BUILDING	
245055 B. WING	04/29/2016
	S, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER 3737 BRYANT A MINNEAPOLIS	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH	VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)
F 156 Continued From page 4 F 156	
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 discharge Janning 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	

Facility ID: 00276

If continuation sheet Page 5 of 42

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION (X3) DATE S		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPL	ETED	
		245055	B. WING _		04/29/20-		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) COMPLETIO DATE	
F 156 F 246 SS=D	when it is determine requires a Medicare notify the resident of hours prior to the cl resident or financia agree with this deci option at that time t process will be exp denial of Medicare 483.15(e)(1) REAS OF NEEDS/PREFE A resident has the r services in the facil accommodations of preferences, excep	 is determined the resident no longer a Medicare skilled service, the facility will e resident or responsible party at least 48 rior to the change in payer source. If the or financially responsible party does not ith this decision, you will be given the t that time to request a demand bill. This will be explained in full at the time of the f Medicare benefits." e)(1) REASONABLE ACCOMMODATION EDS/PREFERENCES nt has the right to reside and receive in the facility with reasonable nodations of individual needs and nees, except when the health or safety of ridual or other residents would be 		6	5/8/16		
	by: Based on observat review the facility fa placed within reach Findings include: R335 was observed resident was seated the bed was pushed call light was out of from the call light be above the bed. R33 never in reach. It's the wall where I car	NT is not met as evidenced tion, interview and document ailed to ensure call lights were for 1 of 1 resident (R335). d on 4/25/16, at 3:22 p.m. The d in a wheelchair. One side of d up against the wall. R335's her reach and hung down ox approximately 18 inches 35 reported, "The call light is always in that position along n't reach it." R335 explained if ne would have to yell for staff		 "R353 s call light has been placed reach. "All residents call lights will be placed within reach. "Facility staff have been educated or requirement to place a resident s calight within reach. "Monitoring to ensure compliance withough weekly call light placement a "The facility QAPI committee will rev the status of the Medicare audits for further recommendations. 	d n the all II be audits. iew		

Facility ID: 00276

If continuation sheet Page 6 of 42

		AND HUMAN SERVICES				FORM	APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES			LE CONSTRUCTION		<u>0938-0391</u> E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					IPLETED
		245055	B. WING				
	PROVIDER OR SUPPLIER	240000	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	04/2	29/2016
					3737 BRYANT AVENUE SOUTH		
WALKER	R METHODIST HEALT	H CENTER		-	MINNEAPOLIS, MN 55409		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
E 246	O antigues of Examples		- -				
F 246		ige 6	F 2	:46	i l		
	to come.						
		a.m. R335's call light again					
		h as it was clipped to the call					
		bed was pushed up against , "I guess I would have to wait					
		es along [to get help]." R335					
	then requested "ple	ease clip the call light to the					
		each it. At 4:15 p.m. R335's					
		 A was visiting the resident ther's call light is rarely in 					
	place for her to use						
		a.m. R335's call light was reach. R335 was seated in					
		e call light was lying on the					
	floor next to the bed	d. When asked if she was able					
		ht she replied, "No. It's on the					
	floor and I'm in my	wheelchair."					
	R335's care plan da	ated 1/21/14, indicated R335					
	had macular degen	eration causing blindness in					
		esident was at risk for falls.					
		o ensure R335's call light was all times, inform the resident					
		pht, and to encourage the					
	resident to use the	light to call for help. The care					
		dent required staff assistance mobility, and ambulation.					
		mobility, and ambulation.					
		a.m. nursing assistant (NA)-C					
		ssigned to care for R335 for					
		amiliar with the her care C verified R335's call light was					
		and she would not have been					
		uld she need to summon help.					
	$Op \frac{4}{27}/16 \text{ of } 10.0$	7 a.m. the assistant director of					
		plained she expected all					

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PRINTED: 06/01/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY
	of COnnection	IDENTIFICATION NOMBER.	A. BUILDIN	G	OMPLETED
		245055	B. WING		04/29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VALKEF	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 246	residents would have even if the resident In addition, the ADC	ge 7 ve their call lights within reach, was unable to utilize the light. DN explained staff should ere within the residents' reach	F 24	6	
F 254 SS=E	provided. 483.15(h)(3) CLEAI GOOD CONDITION	ovide clean bed and bath	F 25	4	6/8/16
	by: Based on observat failed to ensure bec good repair for 3 of R425, R439) and to stored for use were potential to affect al linens. Findings include: On 4/27/16, at 1:15 dining room after lu the table. A nursing was going to to brin for the afternoon. N assistance of two s (a mechanical full b bed and NA-B cove was a large brown of	NT is not met as evidenced ion and interviews the facility d linens were clean and/or in 3 residents observed (R69, o ensure the clean linens in good repair. This had the Il residents who utilized the ll residents who utilized the sistant (NA)-B stated she ig R69 to her room to lie down NA-B stated R69 required the taff with the use of a hoyer lift ody lift). R69 was placed in red her with a blanket. There circular stain approximately 6 o of the bed blanket. At 1:39		"R69, R425, and R439 have all been provided with clean bed linens that are i good repair. "All residents have been provided with clean bed linens that are in good repair. "The facility linen policy has been updat to reflect the facility procedure for storin linens and discarding linens. Laundry st have been educated on the linen policy 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.	ed g aff to

Facility ID: 00276

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	()		E CONSTRUCTION	(X3) DATE	0938-039	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_		COMPLETED		
		245055	B. WING			04/2	29/2016	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF		TH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 254	Continued From pa	age 8	F 2	54				
	behavior of digging had a bowel move	at her buttocks after she has ment (BM). The ADON stated R69's behavior of digging and			the status of the linen audits for fur recommendations.	ther		
a s h fo	a.m. the following supervisor (MS), d	mental tour on 4/28/16, at 9:05 staff was present, maintenance irector of nursing (DON) and dry supervisor (HS/LS). The d:						
	sheets tucked in, th and R69's pillow w the bed. However blanket still contain on 4/27/16. When the fitted sheet was R69's pillow was tu	observed to be made, the he top blanket was pulled up as neatly placed at the head of during the tour, R69's top bed hed the same stained observed the sheets were pulled back s visually worn and stained. urned over and a brown red on the back side of her						
	2. R425's fitted she visible wear marks	eet was very thin and had						
		eet was so thin the mattress ugh it when held up.						
		n linen closet had one fitted in with a hole in it and two fitted ed on sticky food.						
	5. 4 Rain's clean lin sheets that were w	nen closet contained fitted orn and had holes.						
	linens were not in g	sent during the tour verified the good condition and should not on resident's beds or in the All staff stated their						

If continuation sheet Page 9 of 42

		& MEDICAID SERVICES	0.0). 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		245055	B. WING		04	/29/2016
NAME OF F	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 254 F 282 SS=D	linens or in bad cor and/or thrown away linen closets on 4 F sheets that were no declined to look thr in the facility and st problem with nursin On 4/29/16, at 8:26 toured with the HS/ folding clean linen a items were thin or F thrown away and "v The HS/LS went to floor. Fitted sheets cart still warm from through the sheets sheet that was too tossed it to LA-A ar to be used. Within a than 15 fitted sheet HS/LS explained th vendors and the sh the old vender. He not in good condition The facility's policy 7/17/20, indicated " handled in a manne microbial contamin handling the linen."	if staff observed dirty bed ndition they should be replaced y. The HS/LS verified the clean Rains and 7 Gamble had ot in good condition. HS/LS ough other clean linen closets rated there was a system ing and laundry staff. a.m. the laundry room was 'LS. Laundry aide (LA)-A was and explained if any laundry had holes in them they were we never bring up dirty linens." a laundry cart ready for the were pulled from the clean the dryer. The HS/LS sorted one by one. As he got to a thin, had a hole or a stain he hd informed LA-A they were not a short period of time, more is were thrown away. The ley had recently changed leets that are worn were from verified the sheets were thin, on and needed to be replaced. titled "Linens-Clean" dated clean laundry/bedding is to be er that prevents gross ation of the air and persons Although requested, no policy acement was provided. RVICES BY QUALIFIED	F 2			6/8/16
	The services provided b	ded or arranged by the facility				

Facility ID: 00276

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		AND HUMAN SERVICES			FORM	06/01/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245055	B. WING _		04/2	29/2016
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP C		
WALKEF	METHODIST HEALT	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETION DATE
F 282	accordance with ea	age 10 ach resident's written plan of NT is not met as evidenced	F 28	32		
	by: Based on observa review, the facility f were followed for 1 reviewed for accom residents (R69, R3 activities of daily liv Findings include: R335's care plan d had macular deger was at risk for falls provide R335 inclue reach at all times w use and tell resider R335 required the transfers, bed mob On 4/25/16, at 3:22 wheelchair (w/c) all television. The left against the wall. R3 reach, hanging dow located on the wall above R335 bed. I never in reach it's a the wall where I car On 4/26/16 at 9:59 observed to be out	tion, interview and document failed to ensure care plans of 1 residents (R335) amodation of needs and 3 of 5 336, R18) reviewed for ring (ADL's). ated 1/21/14, indicated R335 heration, blind in left eye and . Intervention for staff to ded be sure call light is within when in room, encourage to at where call light was placed. assistance of one staff for ility and ambulation. 2 p.m. R335 was sitting in her one in her room watching the side of R335 bed was pushed 335's call light was out of wn from the call light system approximately 18 inches R335 said "The call light is always in that position along		"R335, R69, R336 and R14 have been reviewed and up necessary. "The care plans of all reside unable to carry out activities have been reviewed and up necessary. "Licensed nursing staff hav educated on the requireme and update the care plan as resident needs. "Monitoring to ensure comp conducted by the DON or d through weekly audits of re- plans. "The facility QAPI committee the status of the care plan a further recommendations.	ents who are s of daily living odated as e been nt to review ccording to pliance will be lesignee sident care ee will review	

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	-	AND HUMAN SERVICES			FORM	06/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245055	B. WING		04/2	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	METHODIST HEALT	H CENTER		737 BRYANT AVENUE SOUTH /INNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	On 4/27/16, at 9:40 again was not in rea w/c alone in her roo the floor next to her could reach her cal the floor and I'm in During an interview nursing assistance person taking care familiar with her car light was noted on t have been able to r During an interview assistant director of she expected all rea within reach even if R69's care plan dat interventions from s ADL's and to thorou nails due to often d Movement (BM). On 4/27/16, at 7:33 sitting eating her br of R69's fingernails imbedded with a dr substance. Later th siting in the dining r resting on the table Nursing assistant (I to bring R69 back to afternoon. NA-B pl	lace for her to use." lace for her to use." a.m. R335 call light once ach. R335 was sitting in her om. The call light was lying on r bed. R335 was asked if she I light R335 replied "No, it's on my w/c." on 4/27/16, at 9:50 a.m. (NA)-C stated she was the R335 for the day and was res. NA-C verified R335's call the floor and R335 would not reach it if she needed help. on 4/27/16, at 10:07 a.m. f nursing (ADON) explained sident to have their call light that resident can't use it. ted 3/25/14, identified staff was to assist with 1 for ughly wash hands and under igging and smearing Bowel a.m. R69 was observed eakfast in the dining room. All and cuticles were dirty, y dark black/brown color at day at 1:15 p.m. R69 was room after lunch with her head her nails remained dirty. NA)-B stated she was going to o her room to lie down for the aced her in bed and covered	F 282			
		aced her in bed and covered No other cares was provided				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		045055	B. WING				
	PROVIDER OR SUPPLIER	245055	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	04/2	29/2016
NAME OF F	ROVIDER OR SUPPLIER				737 BRYANT AVENUE SOUTH		
WALKER	METHODIST HEALT	H CENTER		-	IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 12	F 2	282			
	On 4/27/16, at 1:39 stated R69 got her RN-G stated the bla her fingernails was explain that R69 ha buttocks after she h R69's last BM was interview with the at (ADON) explained of interventions were p and check R69 eve care. On 4/28/16, a R69's nails were din R336's care plan da required one staff a licensed nurses to p care each week. On 4/25/16, at 3:51 have long visible wi underside of her ch substance underne jagged. R336 said " chin I can't see it." I shave her if asked. On 4/26/16, at 10:2 was visiting and sta bathroom for staff te R336 regularly. On 4/27/16 at 9:34 still have long facial fingernails.	 p.m. registered nurse (RN)-G nails done almost everyday. ack/brown substance under feces and further went on to d a habit of digging at her nad bowel movement (BM). that morning. At 1:44 p.m. an ssistant director of nursing due to the behavior, but in place for staff to change ry 2 hours and provide nail t 8:34 a.m. the ADON verified ty with feces. ated 2/8/16, indicated R336 assist for grooming and brovide to enail and fingernail p.m. R336 was observed to nite facial hair along the in. Her fingernails had a black ath them and were long and 'I can't tell if I have hair on my R336 explained staff would 4 a.m. family member (FM)-B ted R336 had a razor in her o use. She staff don't shave a.m. R336 was observed to I hair along her chin and dirty 					
		a.m. NA-C stated she of R336 and was proving care					

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PRINTED: 06/01/2016

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CON	IPLETED
		245055	B. WING		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	R METHODIST HEAL	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 282	for her today. NA- facial hair on R336 this morning. Upor verified seeing faci nails were dirty. F and explained R33 on a daily basis. A R336's nails were trimming. R18's care plan, da was to be clean an R18 was observed long dirty fingernai fingernails. R18 sta fingernails and sho verified R18's un- time of the observa shower on Friday of nails could not hav The facility's Policy "Grooming/Hygien 12/11/12, indicated performed with mo	age 13 C stated she did not see any i's chin while washing her face n looking at R336, NA-C ial hair on R336's chin and her RN-G walked into R336's room 6 did not get her face shaved at 10:07 a.m. the ADON verified in need of cleaning, cutting and ated 3/29/16, indicated R18 id well groomed daily. I on 4/29/16 8:48 a.m. to have ls with heavy dark soil under all ated he did not want long build have had them cut. RN-D clean and long fingernails at the ation. RN-D stated R18 got a of last week and verified the re grown that long in one week. I end Procedure titled e Cares" with a revision date of a residents grooming will be orning and evening cares and nclude shaving both males and	F 282	2		
F 312 SS=D	the resident was d performed by a lice 483.25(a)(3) ADL (DEPENDENT RES A resident who is u daily living receives	CARE PROVIDED FOR	F 312	2		6/8/16

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		0938-039 SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COM	PLETED
		245055			04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 312	Continued From pa	ge 14	F 312	2		
	by: Based on observat review the facility fa nail care were provi R336, R18) reviewe (ADL's) and were da assistance. Findings include: R69 was eating bre 4/27/16, at 7:33 a.m cuticles on both har dark black/brown su 1:15 p.m. R69 was fingernails remained nursing assistant (N to assist R69 to lie of was then assisted to care was provided f On 4/27/16 at 1:39 stated R69 received RN-G stated the bla her fingernails was habit of digging in h movement (BM). Re On 4/27/16, at 1:44 nursing (ADON) ver often had fecal mat to scratching her bu that interventions ha included staff to che every two hours and	AT is not met as evidenced ion, interview and document iled to ensure shaving and ded for 3 of 5 residents (R69, ed for activities of daily living ependent on staff for akfast in the dining room on n. R69's fingernails and nds were imbedded with a dry ubstance. Later that day at in the dining room and her d soiled. A short time later a IA)-B explained she was going down for a rest. The resident o bed by NA-B, but no other or R69 at that time. p.m. registered nurse (RN)-G d nail care almost everyday. ack/brown substance under feces due to the resident's er rectum following a bowel 59's last BM was that morning. p.m. the assistant director of ified she was aware R69 ter under her fingernails due ttocks. The ADON explained ad been put into place which ex and change the resident d provide nail care. When the r went into R69's room NA-B		 "R336, R18 and R69 have received necessary services to maintain go grooming and personal hygiene, in nail care and facial hair removal. "All residents who are unable to cate activities of daily living will received necessary service to maintain groot and personal hygiene, including main facial hair removal. "Nursing staff have been educated facility Grooming/Hygiene Cares pand procedure, including removal hair and having nails be cleaned at manicured. "Monitoring to ensure compliance conducted by the DON or designed through weekly audits of nail care grooming. "The Facility QAPI committee will the status of the grooming and nature audits for further recommendation" 	od ncluding arry out the oming ail care d on the oolicy of facial ind will be e and review il care	

If continuation sheet Page 15 of 42

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED		
		245055	B. WING _			/29/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT				
WALKEF	R METHODIST HEALT	TH CENTER		3737 BRYANT AVENUE SOU MINNEAPOLIS, MN 5540				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE		
F 312	Continued From pa	age 15	F 3	12				
	buttocks and repor	n. R69 was scratching her ted, "It's itchy." The ADON use a wet wipe to clean her						
	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).							
	between 10/14/15 only received nail of	Weekly Bath Audit sheet and 4/27/16, indicated R69 care twice on 3/21/16 and DON was informed of the ernails.						
	ADON verified R69 with feces. The AD member saw a res fingernails they sho are at each dining assistance if they r expected her staff	ew on 4/28/16, at 8:34 a.m. the D's nails yesterday were soiled ON explained that if a staff ident with dirty hands and/or ould offer the wet wipes that room table and offer need it. The ADON verified she to be doing this and no eating at the table with dirty or						
	indicated a diagnos dementia and Alzh dated 2/8/16, indica assist for grooming	orders dated 3/11/16, ses of Type 2 diabetes mellitus, eimer's. R336's care plan ated R336 required one staff g and licensed nurses to d fingernail care each week.						
		1 p.m. R336 was observed to nad long dirty jagged						

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			DMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 04/29/2016	
WALKEP	R METHODIST HEALT	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETIC DATE
F 312	fingernails. R336's along the undersid fingernails was a b can't tell if I have h R336 explained sta asked. On 4/26/16, at 10:2 (FM)-B was visiting in her bathroom fo why staff didn't sha On 4/27/16 at 9:34 sitting up in bed ea came into R336's r continued to have her chin and dirty f On 4/27/16 at 9:56 regularly took care care for her today. breakfast she took provided cares. NA R336's (ADL's) for care provided to R combing her hair, i oral cares. NA-C s hair on R336's chir morning. When R3 verified seeing faci nails. RN-G came explained R336 do a daily basis. RN-C have her chin hairs fine" then said, "I g hair on my face." A had already provid The ADON verified	had long white facial hair e of her chin. Under her lack substance. R336 said "I air on my chin I can't see it." aff would shave her when 24 a.m. R336's family member g and stated R336 had a razor r staff to use. FM-B didn't know ave her regularly. • a.m. R336 was observed ating her breakfast. RN-G room to bring her coffee. R336 the same long facial hair along		312		

Facility ID: 00276

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		AND HUMAN SERVICES				FORM	06/01/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245055	B. WING _			04/;	29/2016
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	H CENTER		-	737 BRYANT AVENUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	explained R336 usu from the therapeuti- they trim her nails. weekly bath audits received nail care. days the staff shoul to all resident which nail cares if needed documented on the On 4/27/16 at 2:01 staff (TR)-A stated manicures for R336 a manicure activity R336 had not atten the last two weeks time she trimmed h A review of R336 W between 2/8/16 to 4 received nail care of The facility's Policy "Grooming/Hygiene 12/11/12, indicated preformed with mor as needed. Care in and females, finger If a diabetic resider by a licensed nurse R18's admission M assessment, dated required extensive hygiene. The care a activities of daily liv care plan developm comfort and dignity	ually got a manicure weekly c recreation (TR) staff where The ADON reviewed R336's and identified R336 had not The ADON explained on bath ld be providing grooming cares in would include shaving and d. The cares should be be bath sheets. p.m. therapeutic recreation she had in the past provided 6. The last time R336 came to was 3/17/16. TR-A stated ided the manicure activity for and didn't remember the last her fingernails. Veekly Bath Audits sheets 4/24/16, indicated R336 once on 2/8/16. and Procedure titled e Cares" revision date resident grooming will be rning and evening cares and cluded shaving both males mails cleaned and manicured. ht nail care will be preformed	F 31	12			

		AND HUMAN SERVICES			FORM	06/01/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		245055	B. WING _		04/	29/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	'H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	Continued From pa	ige 18	F 31	2		
	long, dirty fingernai all nails. The obser the time of the obser was on hospice and bed bath from hosp facility staff. RN-D v scheduled for Wed	a.m. R18 was observed with ls with heavy dark soil under vation was verified by RN-D, at ervation. RN-D explained R18 d received 2 baths per week, a bice staff and shower from the verified R18's bath day was nesdays and nail care would bathing hygiene and daily				
	to be completed by Documentation for blank for 4/6/16 and there had been a co since been correcte 4/27/16 indicated R stated R18 got a sh and verified the nai	th record indicated a bath was the facility on Wednesdays. completion of a bath was d 4/13/16. RN-D explained omputer problem that had ed. The documentation on R18 had refused a bath. RN-D hower on Friday of last week ls could not have grown that RN verified nail care would be a bed bath.				
F 329 SS=D	"Grooming/Hygiene 12/11/12, indicated performed with mor as needed. Care in and females, finger If the resident was performed by a lice	EGIMEN IS FREE FROM	F 32	9		6/8/16
	unnecessary drugs	g regimen must be free from . An unnecessary drug is any excessive dose (including				

Facility ID: 00276

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		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		B. WING _		04/29/2016			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	METHODIST HEALT	H 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	JLD BE COMPLÉTIO		
F 329	Continued From pa	age 19	F 32	29			
	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.						
	resident, the facility who have not used given these drugs of therapy is necessa as diagnosed and of record; and resider drugs receive grad behavioral interven	ehensive assessment of a v must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical nts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on observa review the facility fa blood pressure mo	NT is not met as evidenced tion, interview and document ailed to provide orthostatic nitoring for 1 of 5 residents on edication (R535) and reviewed edications.		"R535 s orthostatic blood pressu been completed. "All residents receiving antipsycho medications who have an order for orthostatic blood pressure had orth blood pressure s completed. "Licensed nursing staff have been educated on the requirement to tal	tic nostatic		
	R535's initial Minim 2/8/16, indicated th antipsychotic media 7-day assessment	to the facility on 2/3/16. num Data Set (MDS) dated e resident was prescribed cation (for psychosis) in the period for the diagnosis of ementia. The 2/8/16, MDS also		educated on the requirement to tal orthostatic blood pressure for resid per MD order. "Monitoring to ensure compliance conducted by the DON or designed through weekly audits of the medic record for residents receiving	lents will be e		

Facility ID: 00276

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245055	B. WING			00/0010	
	PROVIDER OR SUPPLIER	245055	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	29/2016	
	R METHODIST HEALT	HCENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 329	indicated R535 was antidepressant and Review of R535's p admission dated 4/ started on an antips 12.5 mg (milligrams The physician orde orthostatic blood pr three days. Review orthostatic BP's we order was not follow BP's. Review of R535's p indicated to correct Midodrine (increase from hypertension t (drop in BP upon ris dated 4/28/16, direc orthostatic BP ever Review of the cons Communication to recommendation da an order for antipsy require the following of meds: Monthly nursing recommend Guidelines require category of meds: Ortho-BP" Review of an incide at 5:00 a.m. R535 w	-	F 32	29 antipsychotic medications. "The Facility QAPI committee wi the status of the grooming and n audits for further recommendation	ail care		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245055	B. WING _		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• .,	
WALKEF	METHODIST HEALT	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 329	standing alone in h his walker. R535 st On 4/27/16, at 11:0 (RN)-E verified R53 orthostatic blood pu for R535 since his On 4/27/16, at 10:4 stated if a resident antipsychotic media orthostatic blood pu that resident. On 4/27/16, at 12:4 diagnoses of progr psychosis. R535 ha couple of falls after had been doing we pharmacist who wo residents were to h RN-D stated that a been discussed at were reviewed as a RN-D waited for the recommendation. F treatment administ orthostatic BP's ord completed. RN-D s On 4/28/16, at 9:50 the NP. The NP ha BP's for R535. RN- was taken last eve there was a 18 point top number) BP. R	 5 a.m. R535 was observed is room near his recliner with tated he never felt dizzy. 00 a.m. registered nurse 35's record did not indicate an ressure (BP) had been taken admission to the facility. 41 a.m. nurse practitioner (NP) was ambulatory and on an cation she recommended ressures be taken monthly for 40 p.m. RN-D stated R535 had essing Parkinson's and ad fallen at home and had a r admission to the facility but ell lately. RN-D stated it was the build tell the facility which have an orthostatic BP taken. n orthostatic BP's had not the daily meeting when falls a fall intervention for R535. e CP to make a RN-D verified on R535's 2/16, ration record (TAR) the daily dered for 3 days had not been stated she would follow up. 0 a.m. RN-D stated she called id ordered monthly orthostatic -D stated an orthostatic BP ning for R535. RN-D stated nt drop in R535's systolic (the N-D stated nurses were to the physician or NP a drop 	F 3			

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245055	B. WING			04/:	29/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	H CENTER			3737 BRYANT AVENUE SOUTH		
					MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 22	F 3	29			
	On 4/28/16, at 9:55 been passed on in o drop in systolic BP i nothing on the 24 h RN-D then stated th evidence of any cal regarding the drop i she would follow up On 4/28/16, at 10:0 stated she would no related to a BP issu parameters set to c not aware of R535's hypotension or of R RN-E stated R535 v but R535 had not ha On 4/28/16, at 10:0 (LPN)-A stated she if a resident's BP dr would chart it in a p R535 had hypotens BP's did not run hig he took. On 4/28/16, at 10:2 would call the NP o was less than 100 c physician ordered p "depended on what was." On 4/28/16, at 12:0 the facility every mo medications. The C	a.m. RN-E stated nothing had early morning report about a for R535. There was also our report board about it. here was no progress note nor I to the NP or physician in BP for R535. RN-D stated					

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PRINTED: 06/01/2016

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245055	B. WING		04	/29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04	29/2010	
	R METHODIST HEALT	HCENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 329	clinical judgement of orthostatic BP's. Th asked the NP how would write the ord the order the NP has R535 in early Febru taken daily for 3 da orthostatic BP's ord CP stated he made 3/16. The CP also s interim director of n R535 needed an or stated a NP or phys 10-20 point drop in orthostatic BP. On 4/28/16, at 1:35 nursing (ADON) sta manager to schedu TAR and to follow u The ADON also sta recommendation sl manager to clarify w which time frame (n appropriate for the NP made the deciss nurse would have t significant change is orthostatic BP. The specific guideline of The ADON stated s NP on R535's 18 p because of his nee orthostatic hypoten antipsychotic media were discussed dat managers put the f	age 23 stated nurses can make a on how often to take the he CP stated the facility usually often to take them and the NP er. The CP stated he had seen ad written upon admission for uary for orthostatic BP's to be ys. The CP identified the dered had not been done. The e the BP recommendation in stated he had emailed the nursing (IDON) on 4/5/16, that thostatic BP's taken. The CP sician should be informed of a systolic BP during an 6 p.m. the assistant director of ated she expected the nurse le the orthostatic BP on the up to make sure it was done. ated upon receiving the nursing he would expect the nurse with either the NP or the CP monthly or quarterly) would be resident. The ADON stated the ion. The ADON stated the o notify the NP if there was a in the BP when taking an e facility did not follow a f when to call the practitioner. she would have contacted the oint drop in systolic BP ds. He had a diagnosis of sion and was on an cation. The ADON stated falls ily at standup, the nurse all interventions in place and of any discussions regarding	F 3	29			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245055	B. WING _		04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• .,	
WALKEF	METHODIST HEALT	H CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From pa R535's blood press	-	F 32	29		
F 371 SS=F	483.35(i) FOOD PF		F 37	71		6/8/16
	Considered satisfac authorities; and (2) Store, prepare, of under sanitary cond This REQUIREMEN by: Based on observat review the facility fa handling procedure This had the potent the facility. Findings include: During a revisit to th a.m. food service w assistant superviso bare hands while m sandwiches. Slices laid out to be closed heating. FSW-C ran the cooler for more to the cooler door, of sliced cheese, and counter. Without sto	om sources approved or tory by Federal, State or local distribute and serve food ditions NT is not met as evidenced ion, interview and document iled to ensure safe food s were followed in the kitchen ial to affect all 289 residents in ne kitchen on 4/27/16, at 11:03 rorker (FSW)-C, a cook and r, were observed working with laking multiple grilled cheese of bread and cheese were d up and put in a pan for n out of cheese, and went to . FSW-C grabbed the handle entered to get the package of brought it back to the prep opping for handwashing, he plastic-wrapped cheese,		"The grilled cheese sandwiches w discarded immediately. "All food will be handled according facility policy and procedure to ensist safe food handling procedures. "Culinary staff have been educated facility policy and procedure for culinfection control which includes the expectations for proper handwash food handling procedures. "Monitoring to ensure compliance conducted by the Administrator or designee through weekly audits of food preparation and handling proc "The facility QAPI committee will re the status of the food preparation a handling audits for further recommendations.	to the sure d on the linary ing and will be the cess. eview	

Facility ID: 00276

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA). 0938-039 TE SURVEY MPLETED
		245055	B. WING		04/29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 371 F 428 SS=D	prep counter. Whe stated there was no wiped down at the When asked speci washed when com work on food prep acknowledged han stated again, "We down at the beginn The Infection Contr revised 7/11/12, ind Members:Will pra procedures, includi washing" On 4/27/16 at 11:2 supervisor said, "Ye handwashing after cooler and touches food handling." 483.60(c) DRUG F IRREGULAR, ACT The drug regimen reviewed at least of pharmacist. The pharmacist mu the attending physis nursing, and these	rered bread slices sitting on the n about handwashing FSW-C o need to, as the handle got start and end of the shift. fically if hands should be ing back from the cooler to FSW-C said "Yes." FSW-C ds had not been washed then wipe the handle of that cooler ing and end of the shift." rol Culinary Services policy dicated "Culinary Services Staff ctice proper food handling ng but not limited to hand 1 a.m. FSW-D, a kitchen es, I would expect to see a kitchen worker goes to the the handle before resuming EGIMEN REVIEW, REPORT	F 37			6/8/16

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TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245055	B. WING		04/2	29/2016
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP	CODE	
WALKEF	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 428	review the facility fa pharmacist's recom- related to orthostat for 1 of 5 residents medication (R535) medications. Findings include: R535 was admitted R535's initial Minim 2/8/16, indicated the antipsychotic medic 7-day assessment p non-Alzheimer's de indicated R535 was antidepressant and Review of R535's p admission dated 4/3 started on an antips 12.5 mg (milligrams The physician order orthostatic blood pr three days. Review orthostatic BP's we order was not follow BP's. Review of R535's p indicated to correct Midodrine (increase from hypertension t (drop in BP upon ris dated 4/28/16, direct	to the facility on 2/3/16. um Data Set (MDS) dated e resident was prescribed cation (for psychosis) in the period for the diagnosis of mentia. The 2/8/16, MDS also	F 4.	28 "R535 s orthostatic blood been completed. "All residents receiving an medications with a pharmar recommendation to monite blood pressure have had a blood pressure completed "Nurse managers have beet the requirements for procestracking pharmacy recommendations during." Monitoring to ensure comconducted by the DON or through weekly audits of the recommendations related blood pressure monitoring "The facility QAPI committed the status of the pharmacy recommendation audits for recommendations."	tipsychotic acy or orthostatic a orthostatic en educated on essing and nendations d pressure pliance will be designee ne pharmacy to orthostatic ee will review	

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	-	AND HUMAN SERVICES			C		APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· · /	E SURVEY IPLETED
		245055	B. WING			04/2	29/2016
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R METHODIST HEALT	HCENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	Review of the cons Communication to recommendation da an order for antipsy require the following of meds: Monthly nursing recommend resident has an ord Guidelines require category of meds: . Ortho-BP" Review of an incide at 5:00 a.m. R535 w his bed. The incide been reaching for a On 4/27/16, at 9:35 standing alone in h his walker. R535 st 11:01 a.m. R535 w and unassisted with the dining room. At dining room table w pants and sat dowr On 4/27/16, at 11:0 (RN)-E stated R538 fallen when he first pretty steady. RN-E did not indicate an (BP) had been take admission to the fa	ulting pharmacist (CP) Nursing identified a nursing ated 3/8/16, "This resident has rchotic med. Guidelines g monitoring for this category y or quarterly Ortho-BP" and dation dated 4/4/16, "This ler for antipsychotic med. the following monitoring of this "Monthly or quarterly ent report indicated on 4/9/16, was found on the floor next to nt report stated R535 had a blanket on his wheelchair. 6 a.m. R535 was observed is room near his recliner with ated he never felt dizzy. At alked down the hall, steady n his wheeled walker toward 12:30 p.m. R535 stood by the <i>v</i> ith his walker, adjusted his n at the table independently. 0 a.m. registered nurse 5 was not a fall risk. R535 had came to the facility but walked also verified R535's record orthostatic blood pressure en for R535 since his	F 4	28			

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PRINTED: 06/01/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	-	AND HUMAN SERVICES			FORM	06/01/2016 APPROVED 0938-0391
STATEM	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY IPLETED
		245055	B. WING		04/:	29/2016
NAME	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAL	ER METHODIST HEALT	HCENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) I PREF TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 4	28 Continued From pa	ige 28	F 428	3		
	On 4/27/16, at 12:4 diagnoses of progression of psychosis. R535 has couple of falls after had been doing we was steady on his f pharmacist who wo residents were to h Additionally, an orth fall intervention. RN BP's had not been when falls were rev R535. RN-D waited recommendation. F aware of a recommendation. F aware of a recommendat	40 p.m. RN-D stated R535 had essing Parkinson's and ad fallen at home and had a admission to the facility but II lately. RN-D stated R535 feet. RN-D stated it was the build tell the facility which ave an orthostatic BP taken. hostatic BP might be used as a N-D stated that an orthostatic discussed at the daily meeting viewed as a fall intervention for d for the CP to make a RN-D stated she was not hendation from the CP for an e taken for R535. RN-D 2/16 treatment administration he daily orthostatic BP's for R535 had not been also verified the rationale for r blood pressure were d on the medication rd (MAR) for a diagnosis of BP) rather than orthostatic in BP with changes in ted she would follow up.				

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
			A. BUILD	NG		001	
		245055	B. WING			04/2	29/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF		TH CENTER			3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 428	been passed on in	early morning report about a	F4	128			
	nothing on the 24 h RN-D then stated t evidence of any ca	for R535. There was also nour report board about it. there was no progress note nor ill to the NP or physician in BP for R535. RN-D stated p with it.					
	stated she would n related to a BP issu parameters set to o not aware of R535 hypotension or of F RN-E stated R535 but R535 had not h RN-E stated R535 long as he walked	D3 a.m. on 4/28/16, RN-E not call the NP or physician ue unless there were call them. RN-E stated she was 's diagnosis of orthostatic R535's previous falls at home. was a fall risk in at admission had any falls in a long time. was now stable on his feet as with his walker. RN-E stated dent with transfers and					
	(LPN)-A stated she if a resident's BP d would chart it in a p R535 had hypotens	09 a.m. licensed practical nurse e would call the NP or physician propped 8 points or more and progress note. LPN-A stated sion (low BP), and that R535's gh because of the medications					
	would call the NP o was less than 100 physician ordered	24 a.m. LPN-B stated she or physician if the systolic BP or if there were NP or parameters. LPN-B stated it t the resident's baseline BP					
	the facility every m	09 p.m. the CP said he came to onth to review residents' CP stated on the 3/8/16 visit, he					

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STATEMENT	OF DEFICIENCIES DF CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245055	B. WING		04/29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R METHODIST HEALT	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 428	made a recommen monthly or quarterl for R535. The CP s clinical judgement of orthostatic BP's. Th asked the NP how would write the ord the order the NP ha R535 in early Febru taken daily for 3 da orthostatic BP's ord CP stated he made 3/16. The CP also interim director of r R535 needed an or stated a NP or phy 10-20 point drop in orthostatic BP. On 4/28/16, at 1:35 been the IDON sind a few days ago was nursing (ADON). T to the facility once residents' medicati typically mailed the within 3 days of his copy of the recomm manager by the ne stated the CP had The ADON stated s manager to schedu TAR and to follow u The ADON also sta recommendation s manager to clarify which time frame (n appropriate for the	age 30 dation to the facility for y orthostatic BP's to be taken stated nurses can make a on how often to take the ne CP stated the facility usually often to take them and the NP er. The CP stated he had seen ad written upon admission for uary for orthostatic BP's to be bys. The CP identified the dered had not been done. The e the BP recommendation in stated he had emailed the nursing (IDON) on 4/5/16, that rthostatic BP's taken. The CP sician should be informed of a systolic BP during an 6 p.m. the IDON stated she had ce mid January and now as of s the assistant director of he ADON stated the CP came a month to review all the ons. The ADON stated the CP recommendations to her visit and she gave the hard nendation to each nurse xt business day. The ADON been at the facility on 4/5/16. she expected the nurse ule the orthostatic BP on the up to make sure it was done. ated upon receiving the nursing he would expect the nurse with either the NP or the CP monthly or quarterly) would be resident. The ADON stated the	F 4			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
		245055	B. WING _		04/29/20	
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 428 F 431 SS=D	nurse would have to significant change is orthostatic BP. The specific guideline of The ADON stated so NP on R535's 18 po because of his nee orthostatic hypoten antipsychotic medic were discussed dai managers put the fis she was not aware R535's blood press The policy provided Monthly Medication (medication regime the resident's respondet determine that the practicable level of minimizes adverse medication therapy recommendations a nursing and the atter Recommendations documented by the prescriber. The direct licensed nurse will recommendations to intervention (e.g., V documentation.)." 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmaco of records of receip	o notify the NP if there was a in the BP when taking an facility did not follow a f when to call the practitioner. she would have contacted the oint drop in systolic BP ds. He had a diagnosis of sion and was on an cation. The ADON stated falls ly at standup, the nurse all interventions in place and of any discussions regarding sure. I by the facility dated 10/22/13, a Review indicated "The MRR en review) includes evaluating onse to medication therapy to resident maintains the highest functioning and prevents or consequences related to . Findings and are reported to the director of ending physician. are acted upon and facility staff and/or the ector of nursing or designated address and document that do not require physician <i>(ital sign monitoring, labs, PRN</i>	F 42			6/8/16

Facility ID: 00276

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	TIPLE CONSTRUCTION	MB NO.		
	OF CORRECTION	IDENTIFICATION NUMBER:	· /	NG	· · ·	PLETED	
		245055	B. WING _		04/2	9/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 431	records are in orde controlled drugs is reconciled. Drugs and biologica labeled in accordar professional princip appropriate access instructions, and th applicable. In accordance with facility must store a locked compartmen controls, and permin have access to the The facility must pr permanently affixed controlled drugs liss Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri	tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the ill drugs and biologicals in nts under proper temperature it only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can	F 4:	31			
	by: Based on observa review, the facility f cart was locked on (Gamble), observe	ne potential to affect all 20		"The medication cart was locked time of the survey. "All medication carts will be locked not attended to. "Licensed nursing staff have been educated on the requirement to lo medication carts when not attended	d when ck		

Facility ID: 00276

	-	AND HUMAN SERVICES			FORM	: 06/01/2016 APPROVED . 0938-0391
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		245055	B. WING _		04/2	29/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R METHODIST HEALT	HCENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431 F 441 SS=E	Findings include: On 4/25/16 at 6:47 observation, medic 3rd floor (Gamble) no staff nurse arou 6:57 p.m. when reg informed that medic On 4/25/16 at 6:57 medication cart # 3 expectation is if the medication cart, it s RN-B mentioned, " medication are kep On 4/27/16 at 10:5- nursing stated "My cart is to be locked unattended." Polic and procedur STORAGE IN THE reads, "1. Medicatio are locked, and onl COnsultant Pharma authorized are allow Each nurse authori cart keys must carr on duty. These key or loaned out for ar 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infe	 p.m. during a random ation cart # 3 located on the was unlocked and their was nd the medication cart # 3 until jistered nurse (RN)-B was cation was unlock. p.m. RN-B confirmed that the was unlocked and stated her ere is no nurse at the should be locked. In addition, there are 6 residents whose t in this medication cart." 4 a.m. assistant director of expectation is that medication whenever they left e titled MEDICATIION FACILITY dated 10.23.13, on rooms, carts and supplies y licensed nurses, the acist and those lawfully wed access to medications. zed to use medicine room or y these keys at all times while s are not to be left in a drawer ny reason." N CONTROL, PREVENT 	F 43	"Monitoring to ensure compliance conducted by the DON or designe through weekly audits of the medic cards. "The facility QAPI committee will r the status of the food preparation handling audits for further recommendations.	e cation eview	6/8/16

Facility ID: 00276

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED
		245055	B. WING _		04/2	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 441	 Program under whi (1) Investigates, co in the facility; (2) Decides what pershould be applied to (3) Maintains a recording actions related to in (b) Preventing Spree (1) When the Infect determines that a represent the spread isolate the resident (2) The facility must communicable dise from direct contact will tr (3) The facility must hands after each dia hand washing is incorrof professional practice (c) Linens Personnel must hand transport linens so infection. 	ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective nections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. t require staff to wash their irect resident contact for which dicated by accepted be. ndle, store, process and as to prevent the spread of NT is not met as evidenced tion, interview and document ailed to implement effective becedures during morning cares R176) reviewed on clostridium	F 44	"Resident 176 is no longer in iso C-Diff. "All residents with a diagnosis of be provided with a safe, sanitary comfortable environment to help	C-Diff will and	
	communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must hat transport linens so infection. This REQUIREMENT by: Based on observator review,the facility facility facility facility facility facility for 1 of 1 resident (ease or infected skin lesions with residents or their food, if ransmit the disease. t require staff to wash their irect resident contact for which dicated by accepted ce. ndle, store, process and as to prevent the spread of NT is not met as evidenced tion, interview and document ailed to implement effective ocedures during morning cares R176) reviewed on clostridium		C-Diff. "All residents with a diagnosis of be provided with a safe, sanitary	C-Diff will and prevent n of	

Facility ID: 00276

STATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DA	. 0938-039	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CON	MPLETED	
		245055	B. WING _			/29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE		
WALKEI	R METHODIST HEAL	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
F 441	R176's nurse prac 4/22/16, revealed i clostridium difficile pressure ulcers. T having loose stools A form entitled "TH ISOLATION" dated on isolation precau 4/12/16 and those discontinued. On 4/28/16, at 9:4. (RN)-F and a nurs observed assisting her room. RN-F ar shoe covers, gowr the room. RN-F ar shoe covers, gowr the room. RN-F was R176's bottom. RN and donned new g hygiene, and conti cleaned R176's bot red tinged. NA-A re incontinence briefs them. RN-F was th gown, shoe covers and leave the roor hygiene prior to op room. RN-F was o gel on her hands a door knob was not cares. RN-F return briefs and was we covers. RN-F appl RN-F then remove in the garbage. RN first completing ha	age 35 titioner (NP) visit notes, dated the following diagnoses: colitis, recurrent UTI, and he NP further noted "Still s about 2-3 times per day." HIS PATIENT IS ON STRICT d 4/12/16, revealed R176 was utions for c-diff beginning precautions had not been 5 a.m. the nurse manager ing assistant, (NA)-A were g R176 with morning cares in nd NA-A were observed to don as and gloves prior to entering as observed to put lotion on N-F then removed her gloves loves, without performing hand nued to assist NA-A. NA-A witom. Wipes were noted to be eported she needed more s. RN-F reported she would get then observed to remove her s and gloves, open the door n. RN-F did not perform hand being the door and leaving bserved to put hand sanitizer at a nearby medication cart. The is sanitized after completion of ned to room with disposable aring a gown, gloves and foot ied cream to R176's bottom. ed her gloves, placed the gloves J-F donned new gloves, without nd hygiene. R176 asked for the led her the phone with gloved	F 44		lation e facility policy or ene. npliance will be designee observing d washing and ttee will review uarterly for		

If continuation sheet Page 36 of 42

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CONSTRUCTION	· · /	TE SURVEY		
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	со	MPLETED		
		245055	B. WING		04/29/2016			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
WALKEF	METHODIST HEAL	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE		
F 441	obtained a gradua No hand hygiene w changed. RN-F en graduated cylinder clean. RN-F then e toilet, removed her gloves. No hand h glove changes. RN putting clothes on needed to swap ou removed her gown opened the door a performing hand h mechanical lift and gloves and protect straightened out pi NA-A with using th R176 to the wheel linen on the bed w with gloved hands. hygiene between p assisting R176 to t During cares R176 cycle of c-diff infect infections. Upon co reported she used changes and after unable to locate th RN-F reported she the spigot of the ca thought she neede cares were comple between glove cha the room to get su	catheter bag was full. RN-F ted cylinder from the bathroom. was performed or gloves nptied the catheter bag into the without first wiping the spigot emptied the cylinder into the r gloves and donned new ygiene was performed between V-F then assisted NA-A with R176. NA-A identified she ut mechanical lifts. NA-A n, shoe covers and gloves, nd left the room without ygiene. NA-A returned with a d was again wearing a gown, tive shoe covers. RN-F then illows on the bed and assisted e mechanical lift to transfer chair. NA-A straightened the hile RN-F brushed R176's hair . RN-F did not perform hand berforming catheter cares and transfer and brushing her hair. S expressed frustration over a stions and urinary tract ompletion of cares, RN-F hand sanitizer between glove leaving the room. RN-F was e hand sanitizer she used. a used the washcloth to clean atheter. RN-F reported she ed to wash hands only after eted and hand sanitizer was ok anges and while briefly leaving pplies. RN-F reported R176 autions but she was hoping they	F 4					

Facility ID: 00276

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY PLETED	
		045055	B. WING				
	PROVIDER OR SUPPLIER	245055	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	/29/2016	
	R METHODIST HEALT	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 441	 (DON) was informed concerns. The DO with facility policy a newly hired. The D staff to follow the inprocedures. The Hand washing 4/20/12, directed s A. When providing begin and after any your care 3) Before removing them 4) a body substances 5 contaminated obje catheters, bedpans specimen contained. The Clostridium Di revised 7/27/12, di "Transmission-bas shed in feces. a. A (such as commode rectal thermometer with feces may ser spores. b. C. Diff s patients mainly via contaminated surfa Standard Precautic hand washing. 2. If all symptomatic an when C. Diff is sus these residents in are not available, ti cohorted with othe infection. b. Use gl room and during rehygiene after remotive the ser series after remotive the series after remotive the series after remotive the series and a serie	ed of the infection control N reported she was unfamiliar and procedure as she was ON reported she would expect infection control policies and /Hand Hygiene policy, dated taff "Handwashing Indications: resident care 1) Before you y care 2) Between residents in e putting on gloves and after After touching blood or other) After touching any potentially cts such as dressings, s, basins, clothing or linen, ir and so forth"	F 4	41			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245055	B. WING		04/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/23/2010
WALKEF	R METHODIST HEALT	HCENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 441	Continued From pa and water is more of hand rubs."	age 38 efficacious than alcohol-based	F 441		
F 465 SS=E	8/1/13, directed sta hand hygiene" and washcloth to wash downward away fro approximately 2-3 i Firmly grasp the ca and gently wash the tubing." and "remov 483.70(h) SAFE/FUNCTION/ E ENVIRON The facility must pr	-Indwelling policy, last revised off to "wash hands/perform "F. Apply soap to the second the catheter. G. Wiping om urethral opening, cleanse nches of catheter tubing. Itheter to prevent tugging on it e tubing. and "4) Gently dry the ve gloves, wash hands" AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 465	5	6/8/16
	residents, staff and This REQUIREMEN by: Based on observa review the facility fa doors were in good failed to ensure cei insects (ladybugs). affect multiple resid Gamble). Findings include: During multiple res and 4/26/16, with F			"R165, R293, R318, and R335 s ceilin 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 free from scratches and/or gouges. The ceiling lights on 1 Raines are free from insects. The 2 ceiling lights in the dinir room on 1 Raines are free from insects "Resident room ceiling lights are free fr insects. A weekly plan has been developed to address the scratches an	s is e g s. om

Facility ID: 00276

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TATEMENT	F OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE	0938-039 SURVEY PLETED
		245055	B. WING _	_		04/2	9/2016
NAME OF	PROVIDER OR SUPPLIER			ST	I TREET ADDRESS, CITY, STATE, ZIP CODE	04/2	.5/2010
WALKEF	R METHODIST HEALT	TH CENTER			737 BRYANT AVENUE SOUTH INNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 465	On 4/25/16, at 7:09 surveyor "I wish yo these bugs," as she ladybugs crawling of tray table. R165 ex of bugs "the other of was a pile of dead said, "I feel it's a cle anything." During the environn a.m. the following s supervisor (MS), di housekeeper/laund following was noted 1. Multiple ceiling li on 1 Rains containe ceiling lights. 2. 2/3 of one of the room on 1 Rains co ladybugs crawling a fixture where reside 3. Resident (R165, lights had dead lad 4. Resident (R15, F doors on the floors scratch marks that the door. There we wood missing from 5. R235's bathroom missing approxima 6. R438 stated "Th	 p.m. R165 stated to the u could do something about all e pointed to some live on her floor under her bedside cplained there is an infestation day behind by the video stand ladybugs on the floor." R165 eanliness thing more than mental tour on 4/28/16, at 9:05 staff was present, maintenance rector of nursing (DON) and try supervisor (HS/LS). The d: ghts leading to the dining room ed many dead ladybugs in the ceiling lights in the dining pontained live and dead along inside the ceiling light ents eat their meals. R293, R318, R335) ceiling ybugs in them. R17, R235, R300, R438, R535) 4, 5, and 7 Gamble had long went along the bottom 2/3 of re nicks and large gouges of the doors. 	F 46	65	lights on resident units and in the dinit rooms are free from insects. "The facility pest control policy has be reviewed and updated as necessary. Facility staff have been educated on t pest control policy, use of the Work Request email, front desk logs, or uni work request binders to communicate concerns regarding insects in the ceill lights or damage to resident room and bathroom doors. Maintenance staff h been educated on the expectation that resident room and bathroom doors wit free from scratches and gouges and i good repair. "Monitoring to ensure compliance will completed by the Administrator or designee through weekly audits of the resident room and bathroom doors ar ceiling lights. "The facility QAPI committee will revise the status of the resident room and bathroom door and ceiling light audits further recommendations.	een the it e ling d nave at all ill be in l be e nd all ew	

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STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		245055	B. WING		- 04/29/201			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
WALKEP	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE		
F 465	multiple scratches to large gouges on the The three staff press live and dead bugs were ladybugs. All to residents should no or in their rooms an explained he was a throughout the facil pest control compa control the ladybug: vacuuming them up verified that dining should have been to The three staff press doors were not in g need of repairs. The nursing saw an issu order either on line, desk know. Mainten the concern. The M preventive mainten related to cleaning and more mechanic explained any doors taken off and sande had not received ar repair. The MS exp things that needed through of a couple further indicated the floors were toured a but that was no long	door was observed to have the length of her door with 3 e side of her door. Sent during the tour verified the in the ceiling light fixtures three staff presents verified of have to look up while eating nd see dead bugs. The HS/LS ware of the ladybug issues ity. HS/LS verified the facility ny did not have any solution to s other than his staff o when needed. HS/LS room ceiling light on 1 Rains aken care of right away. Sent during the tour verified the ood conditions and were in ne MS explained if staff or ue they would fill out a work , paper form or let the front nance staff was informed of IS stated he did have a ance plan but it was more the vents, monitoring fire drills cal type items. The HS/LS s with deep gouges would be ed down. The MS stated he ny request for doors in need of lained his staff watched for repair, "we do a facility walk e of floors a week." The MS ere had been a sheet of which and what things needed repair ger done. The MS could not e he or his staff did a walk	F 4	65				

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		AND HUMAN SERVICES				FORM	06/01/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245055	B. WING			04/:	29/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
WALKEF	R METHODIST HEALT	HCENTER		-	737 BRYANT AVENUE SOUTH /INNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	Adams pest control "Customer pest sig and 4/26/16 ladybu and the conference The service date by 11/9/15, and indicat treatment, recomm units and common	lity's pest control book from I, Inc. indicated under hting," on 10/13/15, 4/21/16 gs were seen on 4 gamble room by the dental office. Adams pest control Inc. was ted action taken was exterior end using vacuum for interior area. have a policy or procedure for	F	465			

Facility ID: 00276

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		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	50	ISTAIL	FORM	05/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DISTRUCTION Building 01		E SURVEY PLETED
		245055	B. WING			04/	28/2016
NAME OF F	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	METHODIST HEALT	HCENTER			BRYANT AVENUE SOUTH IEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Division time of this survey, Center was found r with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National	Survey was conducted by the nent of Public Safety, State on on April 28, 2016. At the Walker Methodist Health not in substantial compliance hts for participation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 5510	R THE FIRE SAFETY (-TAGS) TO: pections Division Suite 145			EPOC		
	By email to:						
	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 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.

MATERIAL INC. Material Control Material Control <th></th> <th></th> <th>AND HUMAN SERVICES & MEDICAID SERVICES</th> <th></th> <th></th> <th></th> <th></th> <th>FORM</th> <th>05/26/2016 APPROVED 0938-0391</th>			AND HUMAN SERVICES & MEDICAID SERVICES					FORM	05/26/2016 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STREL 20 CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS. MIN 55409 VALUER METHODIST HEALTH CENTER STREET ADDRESS. CITY. STREL 20 CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS. MIN 55409 VALUE TAG SURMARY STREMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PREINX REGULATORY OR USE IDENTIFYING INFORMATION) D PATERN TAG PROVIDERS PLAN OF CORRECTION (EQACI CORRECTIVE ACTON STORUDUS CROSS.REFERENCE 10 THE APPROMRIATE OCROSS.REFERENCE 10 THE APPROMENTION: 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 tille of the person responsible for correction and monitoring to provent a recocurrence of the deficiency. Walker Methodist Health Center is a 7-story building with a full basement. The building and the 1 addition are of the same type of construction. Recause the original building This building has a full basement and is fully free alarm system with smoke delection in the corritors and spac	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l ' '					
WALKER METHODIST HEALTH CENTER 373 BERVAT AVENUE SOUTH MINREAPOLIS, MN 55409 PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFX PREFX K 000 Continued From page 1 Marian.Whitey@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: K 000 K 000 Continued From page 1 Marian.Whitey@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: K 000 1. A description of what has been, or will be, done to correct the deficiency. Angel 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 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. Because the original building and the 1 addition are of the same type of construction. Because the origin building and the 1 addition gas a full basement and is fully fire sprinkered throughout. The facility has a cipacity of 320 beds and had a census of 280 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			245055	B. WING			e j	04/2	28/2016
WALKER METHOOIST HEALTH CENTER MINNEAPOLIS, MN 55403 (%1) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BS FULL REGULATORY OR LSC DENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S LANG FOR CORRECTION (EACH ORFCORVER OWNST BE PREADED BS FULL REGULATORY OR LSC DENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S LANG FOR CORRECTION (EACH ORFCORVER ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY WORKST DEPREADED BS FULL REGULATORY OR LSC DENTIFYING INFORMATION) N NO K 000 Continued From page 1 Marian. Whitney@state.mn.us K 000 K 000 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: K 000 1. A description of what has been, or will be, done to correction and monitoring to prevent a reoccurrence of the deficiency. X 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 to the NOT 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. Because the oof Type II(222) construction. Because the oof Type II(222) construction. The facility has a surveyed as one building. This building has a full basement and is fully fire sprinklered throughout. The facility has a survey 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:	NAME OF F	PROVIDER OR SUPPLIER					DDE		
Market TAO reach deprecision values the precessed by Full, Recultation of Values (DeprintPrivice) in Promettion, Precision of Values (DeprintPrivice) in Promettion, Precision of Values (DeprintPrivice) in Promettion, Deficiency, Precision of Values (DeprintPrivice) in Promettion, Deficiency, Construction approximate (CROSER/EFERCE) of Values (Deprivice) and (Deprivice	WALKER	METHODIST HEALT	H CENTER		11 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(22) construction. In 1983, a 7 story addition was constructed to the North that was determined to be of 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:	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD	BE	COMPLETION
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	Marian Whitney@s Angela Kappenmar THE PLAN OF COD DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/or responsible for comprevent a reoccurre Walker Methodist H building with a full th constructed at 2 diff story building was of determined to be on 1983, a 7 story add North that was deter construction. Becan the 1 addition are of construction, the far building. This building has a sprinklered through alarm system with corridors and spac monitored for autor	A state.mn.us and (@state.mn.us) RRECTION FOR EACH (T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. Health Center is a 7-story pasement. The building was ferent times. The original 5 constructed in 1964 and was f Type II(222) construction. In lition was constructed to the ermined to be of Type II(222) use the original building and of the same type of acility was surveyed as one full basement and is fully fire hout. The facility has a fire smoke detection in the es open to the corridors that is matic fire department	K	000				
	K 030	beds and had a ce survey. The requirement a NOT MET as evide	nsus of 290 at the time of the t 42 CFR, Subpart 483.70(a) is enced by:	ĸ	02	9			6/8/16

Event ID: I69L21

Facility ID: 00276

		AND HUMAN SERVICES			M APPROVE 0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
	245055		B, WING		4/28/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WALKER	METHODIST HEALT	TH 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) COMPLETIO DATE
K 029	Continued From pa	age 2	K 029	9	
SS=E		- -			
	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro- the approved autor option is used, the other spaces by sn doors. Doors are s field-applied protect 48 inches from the permitted. 19.3.2 This STANDARD Based on a facility facility failed to pro- areas in accordance NFPA 101 -2000 et 8.4.1	a construction (with o hour an approved automatic fire em in accordance with 8.4.1 atects hazardous areas. When matic fire extinguishing system areas are separated from hoke resisting partitions and self-closing and non-rated or ative plates that do not exceed bottom of the door are 2.1 is not met as evidenced by: of tour and staff interview, the vide protection of hazardous ce with the requirements of dition, Section 19.3.2.1 and		"The self-closing doors leading to the commercial laundry will have devices added and tied to the buildings fire alarr system. The 2nd floor Gamble laundry room door has been fixed to close and positively latch.	n
	April 28, 2016, it w self-closing doors room in the basem that are not tied inf	ween 9:00 AM 3:30: PM on as observed that 1) The to the commercial laundry tent are held open with devices to the fire alarm system and 2) door on the 2nd floor Gamble, latch.		"All maintenance staff have been educated on the requirements of corrido doors to close and positively latch. All s 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 Supervision or designee through random audits of self-closing doors and corridors doors	taff t
		tice was verified by the Director the time of discovery.		latching function. "The Facility QAPI committee will review the status of the grooming and nail care audits for further recommendations.	•
K 046 SS=F		AFETY CODE STANDARD	K 04	6	6/8/16
	is provided automa 18.2.9.1, 19.2.9.1. This STANDARD	g of at least 1 1/2 hour duration atically in accordance with 7.9. is not met as evidenced by: ent review and staff interview,		"The battery operated emergency egre	ss

Facility ID: 00276

If continuation sheet Page 3 of 9

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			and in case of the second s	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/28/2016	
		245055	B, WING			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NALKEF	R METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
K 046	lighting in accordar deficient practice c Findings include: On a facility tour be on April 28, 2016, in could not provide d records for the batt egress lighting. This deficient pract	age 3 provide adequate emergency nce with LSC (00) 19.2.8. This an effect all 29 residents. etween 9:00 AM and 3:30 PM t was observed that the facility locumentation of testing ery operated emergency tice was verified by the Director the time of the discovery.	K 04	 B Iighting has been tested with test rest documented. "A Documentation log was created for recording of the testing of all battery operated emergency egress lighting. "All maintenance staff have been educated on the requirements of test and recording of the battery operate emergency egress lighting. "Monitoring to ensure compliance w completed by the Maintenance Support or designee through random audits emergency lighting testing documentation audits for furt recommendations. 	or the sting d ill be ervisor of the ntation eview	
K 054 SS=F	All required smoke activating door hole maintained, inspec with the manufactu This STANDARD Based on docume the facility has not testing of the smok system in accordan 7-3.2.1. This defici residents. Findings include: On facility tour beth April 28, 2016, It w smoke detector se 02/10/2014, which	AFETY CODE STANDARD detectors, including those d-open devices, are approved, ted and tested in accordance irrer's specifications. 9.6.1.3 is not met as evidenced by: ent review and staff interview, been conducting sensitivity te detectors on the fire alarm ince with NFPA 72 (99), Sec. ent practice could affect all 44		 "The smoke detector sensitivity tes been completed. All battery operate smoke alarms have been inspected "The smoke detector sensitivity test completed annually and results documented. All battery operated si alarms will be inspected annually ar results documented. "All maintenance staff have been educated on the requirement to con the smoke detector sensitivity test annually and the testing and documentation of all battery operate smoke alarms annually. "Monitoring to ensure compliance was 	id I. : will be moke nd nplete ed	6/8/16

Event ID: I69L21

Facility ID: 00276

If continuation sheet Page 4 of 9

PRINTED: 05/26/2016

		AND HUMAN SERVICES					APPROVE 0938-039
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			= CONSTRUCTION (X3)	DATE	SURVEY
	9 2	245055	B, WING			04/2	8/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
NALKER		HCENTER			737 BRYANT AVENUE SOUTH IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIC DATE
K 054	Continued From pa This was confirmed Maintenance at the	d by the Director of	КO	54	completed by the Maintenance Superv or designee through random audits of the smoke detector sensitivity test documentation and the battery operate smoke detector inspection documentation. "The Facility QAPI committee will reviet the status of the smoke detector testin documentation audits for further recommendations.	the d w g	
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 		κo	66			6/8/16
	readily available to permitted. 19.7. This STANDARD Based on observa interview, the facili designated resider NFPA LSC (00) Ec	ashtrays can be emptied are all areas where smoking is 4 is not met as evidenced by: ations, policy review and staff ty failed to follow policy for the nt smoking in accordance with lition Section 19.7.4, and the policy. This deficient practice			"The cigarette butts disposed of in the general use trash can have been remo and disposed of appropriately. "All cigarette butts will be disposed of properly according to designated smo	oved	

Event ID: I69L21

Facility ID: 00276

If continuation sheet Page 5 of 9

PRINTED: 05/26/2016

	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MULTIP	LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILDING 01 - BUILDING 01		COMPLETE	
245055		B. WING		04/2	8/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER		H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 066	Continued From pa	age 5	K 066			
	could affect all 298	-		areas and the facility smoking pol		
	Findings include:			"All staff have been educated on proper disposal of cigarette butts, maintenance staff have been edu	All	
	April 28, 2016, It w cigarette butts disp	ween 9:00 AM and 3:30 PM on as observed that the were posed of in a general use trash	I.	the requirement of regular removing cigarette butt disposal containers "Monitoring to ensure compliance	e of all will be	
		ted employee smoking area.		completed by the Maintenance So or designee by completing randou of the general use trash cans and	n audits I	
		tice was verified by the Director the time of discovery.		cigarette butt disposal containers "The Facility QAPI committee will the status of the general use tras and cigarette butt disposal contai audits for further recommendatio	review h can ner	
K 076 SS=E	NFPA 101 LIFE SA	AFETY CODE STANDARD	K 076			6/8/16
00 2		ge and administration areas in accordance with NFPA 99, h Care Facilities.				
	3,000 cu.ft. are en separation.	e locations of greater than closed by a one-hour				
	3,000 cu.ft. are vei	upply systems of greater than nted to the outside. 9), 8-3.1.11.1 (NFPA 99),				
	This STANDARD Based on observa failed to maintain t	is not met as evidenced by: ation and interview, the facility he medical gas storage in		"The oxygen tanks were remove room 2W24 and stored in design		
	accordance with N could affect the res	IFPA 99. This deficient practice sidents.		oxygen storage room. "All oxygen tanks will be stored in designated oxygen storage room		
	Findings include:			accordance with NFPA 99. "All staff have been educated on		
	PM on April 28, 20 there were three o	n between 9:00 AM and 3:30 16, observation revealed that xygen cylinders stored in room t ventilated to the outside.		facility policy and procedure rega proper storage of oxygen tanks. "Monitoring to ensure compliance completed by the Maintenance S	e will be	

Event ID: I69L21

Facility ID: 00276

If continuation sheet Page 6 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		& MEDICAID SERVICES					0938-0391
			(NO) 1411	TIDL			SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3 01 - BUILDING 01		PLETED
		245055	B. WING	_		04/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER			737 BRYANT AVENUE SOUTH IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
K 076		ige 6 ice was verified by the Director he time of the discovery.	ĸ)76	or designee by completing random au oxygen tank. "The Facility QAPI committee will revi the status of the oxygen tank storage audits for further recommendations.		
K 143 SS=E	Transferring of liqui to another shall be specifically designa as follows:	FETY CODE STANDARD id oxygen from one container accomplished at a location ated for the transferring that is any portion of a facility	Κ 1	143			6/8/16
	wherein patients are housed, examin of a fire barrier of 1 construction; and (b) the area that is sprinklered, and ha and (c) in an area that is that transferring is the immediate area	ned, or treated by a separation -hour fire-resistive mechanically ventilated, as ceramic or concrete flooring; s posted with signs indicating occurring, and that smoking in			×		
	Based on observa building does not m proper arrangement transferring of liquid another per NFPA practice could affect Findings include: On a tour of the fact 3:30 PM on April 20	s not met as evidenced by: tion and staff interview, this neet the requirements for the of room intended for the d oxygen from one container to 99 8-6.2.5.2. This deficient			"The holes in the concrete ceiling of Gamble oxygen transfilling room expo the post tension cables have been patched. "All ceiling holes in the oxygen transfi rooms exposing post tension cables I been patched. "Maintenance staff have been educat on the requirement for oxygen transfi rooms to have to open holes or expo to post tension cables. "Monitoring to ensure compliance wil	osing Illing have ted Iling sure	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I69L21

Facility ID: 00276

If continuation sheet Page 7 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/26/2016 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	G 01 - BUILDING 01	COMF	LETED
		245055	B. WING		04/2	8/2016
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
VALKER	METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTI MINNEAPOLIS, MN 55409	H	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
K 143	Continued From pa	ae 7	K 14	.3		
	3rd floor Gamble or exposed the post te	kygen transfilling room, that ension cables.		conducted by the Main or designee through ra oxygen transfilling roor	ndom audits of the n.	
	of Maintenance at t	ice was verified by the Director he time of the discovery.		"The Facility QAPI con the status of the oxyge audits for further recon	en transfilling room	01014.0
K 144 SS=E		FETY CODE STANDARD	K 14	4		6/8/16
	under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (I 110)	ed weekly and exercised ninutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA				
	Based on docume interview, the facilit emergency genera requirements of NF	s not met as evidenced by: ntation review and staff y failed to maintain the tor in accordance with the PA 110-1999 edition, Section practice could affect all 76		"The weekly generato been completed and d cool down period has documentation of the r load tests. "All weekly generator i documented going for	ocumented. The been added to monthly generator nspections will be	
	Findings include:	0.00 AM and 0.00 DM	1	periods following the n be documented going "All maintenance staff	nonthly load test will forward.	
	on April 28, 2016, o Weekly generator i conducted between and April 19, 2016	etween 9:00 AM and 3:30 PM observation revealed that 1) nspections were not n the dates of March 22, 2016 and, eparate documented cool-down		educated on the requi maintaining the weekly inspection documenta down period of the mo "Monitoring to ensure	rements of y generator tion and the cool onthly load test. compliance will be	
	period during the n These deficient pra	nonthly generator load tests. actices were verified by the nance at the time of the		conducted by the Mair or designee through ra documentation logs. "The Facility QAPI cor the status of the gene audits for further recor	ntenance Supervisor andom audits of the nmittee will review rator documentation	
K 147 SS=E		FETY CODE STANDARD	K 1			6/8/16
		d equipment shall be in ational Electrical Code. 9-1.2				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I69L21

Facility ID: 00276

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 01 - BUILDING 01	(X3) DATE SURVEY COMPLETED		
	245055		B. WING		04/2	04/28/2016	
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	DE	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
K 147	Based on observa facility failed to com 70 The National Ele practice could affect Findings include: On a facility tour be on April 28, 2016, co opening in the wall side had live electric capped with wire n This deficient pract	19.9.1 s not met as evidenced by: tion and staff interview, the nply with NFPA 99 and NFPA ectric Code. This deficient of the resident. etween 9:00 AM and 3:30 PM observation revealed that an on the Raines, 5th floor, south ical wires exposed that were	K 147	"The weekly generator inspe been completed and docume cool down period has been a documentation of the monthly load tests. "All weekly generator inspect documented going forward." periods following the monthly be documented going forware "All maintenance staff have b educated on the requirement maintaining the weekly gener inspection documentation an down period of the monthly lo "Monitoring to ensure compli- conducted by the Maintenand or designee through random documentation logs. "The Facility QAPI committee the status of the generator do audits for further recommend	ented. The dded to y generator ions will be All cool down load test will d. been s of rator d the cool bad test. ance will be ce Supervisor audits of the e will review boumentation		



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Walker Methodist Health Center May 13, 2016 Page 2

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

PRINTED: 06/01/2016 FORM APPROVED

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00276	B. WING		04/2	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	H CENTER	ANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa	nether a violation has been				
	requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	a rule provided at the tag le number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 05/20/16

STATE FORM

If continuation sheet 1 of 47

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
00276		B. WING		04/29/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WALKEF	R METHODIST HEALT		YANT AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, the corrected prior to e Minnesota Department" provider and the fo issued. When corr sign and date, mak mail or email to: Mi Health Regulation Certification P.O. E	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for indicate in the electronic cess, under the heading ne date your orders will be electronically submitting to the nent of Health. , 28, and 29, 2016, surveyors 's staff, visited the above llowing correction orders are rections are completed, please is a copy of these orders and innesota Department of Health Division, Licensing and Box 64900, St. Paul, Minnesota	r			
		tate licensing survey, the ts were investigated:				
		of complaint H5055194 was N Rule 4658.0525 Subp. 6B.				
	H5055193, H5055 ⁻	omplaints H5055191, 187, H5055192 were also re found to be unsubstantiated				
	the State Licensing federal software. Ta	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE	number appears in the far left D Prefix Tag." The state compliance is listed in the				

PRINTED: 06/01/2016 FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/29/2016	
		00276	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
VALKER	R METHODIST HEALT		YANT AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 2	2 000			
2 565	and replaces the "T correction order. The findings which are after the statement evidence by." Follo are the Suggested Time period for Co PLEASE DISREGA FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI THIS WILL APPEA THERE IS NO REC PLAN OF CORREC MINNESOTA STAT MN Rule 4658.040 Plan of Care; Use Subp. 3. Use. A c must be used by all care of the residen	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. NR ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF TE STATUTES/RULES. 5 Subp. 3 Comprehensive omprehensive plan of care Il personnel involved in the				6/8/16
	review, the facility f were followed for 1 reviewed for accon	ion, interview and document failed to ensure care plans of 1 residents (R335) nmodation of needs and 3 of 5 336, R18) reviewed for ring (ADL's).	5	Corrected.		
	Findings include:					

l69L11

If continuation sheet 3 of 47

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WALKE	R METHODIST HEALT	HCENTER	YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 3	2 565			
	had macular deger was at risk for falls provide R335 inclu- reach at all times w use and tell resider R335 required the transfers, bed mob On 4/25/16, at 3:22 wheelchair (w/c) al- television. The left against the wall. R3 reach, hanging dow located on the wall above R335 bed. I never in reach it's a the wall where I can On 4/26/16 at 9:59 observed to be out R335 said " I guess some comes along family member (FM light was rarely in p On 4/27/16, at 9:40 again was not in re w/c alone in her roo the floor next to he could reach her can the floor and I'm in During an interview nursing assistance person taking care familiar with her can light was noted on	a.m. R335 call light again was of reach. If she needed help, s I would have to wait until J." Later that day at 4:15 p.m. A)-A said, "My mother's call blace for her to use." D a.m. R335 call light once ach. R335 was sitting in her om. The call light was lying on r bed. R335 was asked if she Il light R335 replied "No, it's on	3			

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00276	B. WING		04/	29/2016
PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
METHODIST HEALT	IH CENTER				
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
Continued From pa	age 4	2 565			
assistant director of she expected all re- within reach even if R69's care plan da interventions from ADL's and to thoro nails due to often of Movement (BM). On 4/27/16, at 7:33 sitting eating her bu of R69's fingernails imbedded with a dr substance. Later th siting in the dining resting on the table Nursing assistant (to bring R69 back to afternoon. NA-B p	of nursing (ADON) explained esident to have their call light f that resident can't use it. ted 3/25/14, identified staff was to assist with 1 for ughly wash hands and under digging and smearing Bowel 8 a.m. R69 was observed reakfast in the dining room. A s and cuticles were dirty, ry dark black/brown color hat day at 1:15 p.m. R69 was room after lunch with her head e her nails remained dirty. NA)-B stated she was going to to her room to lie down for the laced her in bed and covered				
On 4/27/16, at 1:39 stated R69 got her RN-G stated the bl her fingernails was explain that R69 ha buttocks after she R69's last BM was interview with the a (ADON) explained interventions were and check R69 events care. On 4/28/16, at	nails done almost everyday. ack/brown substance under feces and further went on to ad a habit of digging at her had bowel movement (BM). that morning. At 1:44 p.m. an assistant director of nursing due to the behavior, put in place for staff to change ery 2 hours and provide nail at 8:34 a.m. the ADON verified	•			
	PROVIDER OR SUPPLIER METHODIST HEAL SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa During an interview assistant director of she expected all re- within reach even i R69's care plan da interventions from ADL's and to thoro nails due to often of Movement (BM). On 4/27/16, at 7:33 sitting eating her b of R69's fingernails imbedded with a di substance. Later th sitting in the dining resting on the table Nursing assistant (to bring R69 back f afternoon. NA-B p her with a blanket. to R69. On 4/27/16, at 1:33 stated R69 got her RN-G stated the bl her fingernails was explain that R69 ha buttocks after she R69's last BM was interview with the a (ADON) explained interventions were and check R69 evec care. On 4/28/16, at	OF CORRECTION IDENTIFICATION NUMBER: 00276 PROVIDER OR SUPPLIER STREET A 3737 BF MINNEA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. A 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 sitting in the dining room after lunch with her heac 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)-O 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 nurusing (ADON) explained due to the behavior,	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00276 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETHODIST HEALTH CENTER DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETH TAG Continued From page 4 2 565 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 done almost everyday. On 4/27/16, at 1:39 p.m. registered nurse (RN)-G stated R69 got her nails done almost everyday. RN-G stated Re9 the nails done almost everyday. RN-G stated R69 had a habit of digging at her buttocks after she had bowel movement (BM). R69's last BM was that morni	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM 00276 B. WING 004/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH 3737 BRYANT AVENUE SOUTH METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOUTH INCACH DEFICIENCY MUST BE PRECEDED BY FULL ID REQUATORY OR LSCIDENTFYING INFORMATION) ID REQUATORY OR LSCIDENTFYING INFORMATION) TAG PREFIX CROSS-HEFENCED TO THE APPROPRIATE DEFICIENCY Continued From page 4 2 565 During an interview on 4/27/16, at 10:07 a.m. assistant director of nursing (ADON) explained the expected all 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 thoroughy 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 dity, thrusing assistant (NA)-E 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 blacket. No other cares was grovided to R69. On 4/27/16, at 1:39 p.m. registered nurse (RN).G stated R69 back to her alis formalined dirty. NURSING assistant (Mi-PC Marine).G stated R69 back to her alis formaling a ther buttocks after she had bowel moverment (BM). R69's last BW was htat moroning at har 4.4

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00276	B. WING		04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
WALKER			YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	age 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.					
	was visiting and sta	24 a.m. family member (FM)-B ated R336 had a razor in her to use. She staff don't shave				
		a.m. R336 was observed to I hair along her chin and dirty				
	regularly took care for her today. NA- facial hair on R336 this morning. Upor verified seeing faci nails were dirty. F and explained R33 on a daily basis. A	a.m. NA-C stated she of R336 and was proving care C stated she did not see any 's chin while washing her face I looking at R336, NA-C al hair on R336's chin and her N-G walked into R336's room 6 did not get her face shaved t 10:07 a.m. the ADON verified in need of cleaning, cutting and				
		ated 3/29/16, indicated R18 d well groomed daily.				
	long dirty fingernai fingernails. R18 sta fingernails and sho	on 4/29/16 8:48 a.m. to have Is with heavy dark soil under al ated he did not want long puld have had them cut. RN-D	I			
nnesota De ATE FORM	epartment of Health	uu nave nau them cut. MN-D	6899	69L11	If continua	tion sheet 6

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00276	B. WING		04/29/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
ALKER	METHODIST HEALT		YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 6	2 565			
	time of the observa shower on Friday on nails could not have	lean and long fingernails at the ation. RN-D stated R18 got a of last week and verified the e grown that long in one week.				
	"Grooming/Hygiene 12/11/12, indicated performed with mo as needed. Care in females, fingernails	and Procedure titled e Cares" with a revision date of residents grooming will be rning and evening cares and nclude shaving both males and s cleaned and manicured. If abetic nail care would be ensed nurse.				
	The director of nurs review and revise p to ensuring the car resident is followed designee could dev and develop a mor	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related e plan for each individual d. The director of nursing or velop a system to educate staff nitoring system to ensure staff as directed by the written plan				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			6/8/16
	comprehensive res home must ensure B. a resident who activities of daily liv	o is unable to carry out ring receives the necessary n good nutrition, grooming,				
	This MN Requirem	ent is not met as evidenced				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	HCENTER	/ANT AVENU POLIS, MN ያ			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLET DATE
2 920	Continued From pa	age 7	2 920			
	review the facility fa nail care were prov R336, R18) review	ion, interview and document ailed to ensure shaving and rided for 3 of 5 residents (R69, ed for activities of daily living lependent on staff for		Corrected.		
	Findings include:					
	4/27/16, at 7:33 a.r cuticles on both ha dark black/brown s 1:15 p.m. R69 was fingernails remaine nursing assistant (I to assist R69 to lie was then assisted to	eakfast in the dining room on n. R69's fingernails and nds were imbedded with a dry ubstance. Later that day at in the dining room and her ed soiled. A short time later a NA)-B explained she was going down for a rest. The resident to bed by NA-B, but no other for R69 at that time.				
	stated R69 receive RN-G stated the bl her fingernails was habit of digging in h	p.m. registered nurse (RN)-G d nail care almost everyday. ack/brown substance under feces due to the resident's ner rectum following a bowel 69's last BM was that morning.				
	nursing (ADON) ve often had fecal mar to scratching her be that interventions h included staff to ch every two hours an ADON and surveyo	p.m. the assistant director of prified she was aware R69 tter under her fingernails due uttocks. The ADON explained ad been put into place which eck and change the resident of provide nail care. When the pr went into R69's room NA-B n. R69 was scratching her				
nnoosta D	buttocks and repor	ted, "It's itchy." The ADON use a wet wipe to clean her				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
WALKEF	R METHODIST HEALT					
(X4) ID	SUMMARY ST		POLIS, MN 55	PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 920	Continued From pa	age 8	2 920			
	indicated R69 requipersonal hygiene. I identified interventi ADL's and to thoro nails due to often of Movement (BM). A review of R69's V between 10/14/15 only received nail of	ata Set (MDS) dated 2/15/16, irred staff assistance with R69's care plan dated 3/25/14, ons of staff assist of 1 with ughly wash hands and under ligging and smearing Bowel Weekly Bath Audit sheet and 4/27/16, indicated R69 care twice on 3/21/16 and DON was informed of the ernails.				
	ADON verified R69 with feces. The AD member saw a res fingernails they sho are at each dining assistance if they r expected her staff	w on 4/28/16, at 8:34 a.m. the O's nails yesterday were soiled ON explained that if a staff ident with dirty hands and/or build offer the wet wipes that room table and offer need it. The ADON verified she to be doing this and no eating at the table with dirty or				
	indicated a diagnos dementia and Alzh dated 2/8/16, indica assist for grooming	orders dated 3/11/16, ses of Type 2 diabetes mellitus eimer's. R336's care plan ated R336 required one staff and licensed nurses to I fingernail care each week.	,			
	be unshaven and h fingernails. R336's along the underside fingernails was a b can't tell if I have h	I p.m. R336 was observed to had long dirty jagged had long white facial hair e of her chin. Under her lack substance. R336 said "I air on my chin I can't see it." aff would shave her when				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00276	B. WING		04/	04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	_		
		3737 BB	YANT AVENUE				
VALKEH	R METHODIST HEALT	IH CENTER MINNEA	POLIS, MN 55	5409			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	COMPLET DATE	
				DEFICIENC	CY)		
2 920	Continued From pa	age 9	2 920				
	asked.	-					
	askeu.						
	On 4/26/16, at 10:2	24 a.m. R336's family member					
		and stated R336 had a razor					
		r staff to use. FM-B didn't know	/				
	why staff didn't sha	ive ner regularly.					
	On 4/27/16 at 9:34	a.m. R336 was observed					
		ting her breakfast. RN-G					
		oom to bring her coffee. R336					
		the same long facial hair along					
	her chin and dirty fi	ingernails.					
	$\Omega_{n} 1/27/16$ at 9.56	a.m. NA-C stated she					
		of R336 and was providing					
		NA-C explained after					
		R336 to the bathroom and					
		A-C verified she was done with					
		the morning. NA-C stated the					
		336 included washing her face ncontinent cares if needed and					
		tated she did not see any facia					
		while washing her face this	•				
		36 was observed, NA-C					
		al hair on R336's chin and dirty	/				
		into R336's room and					
		es not get her face shaved on					
		asked R336 if she wanted to shaved. R336 replied "it's					
		uess I should mind I do have					
		at 10:07 a.m. NA-C verified she					
	had already provide	ed grooming cares to R336.					
		that R336 nails were in need					
		and trimming. The ADON					
		ually got a manicure weekly					
		ic recreation (TR) staff where The ADON reviewed R336's					
		and identified R336 had not					
		The ADON explained on bath					
		ld be providing grooming cares	_			1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00276	B. WING		04/29/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1	
VALKEF	R METHODIST HEALT	HCENIER	YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 10	2 920			
		h would include shaving and d. The cares should be bath sheets.				
	staff (TR)-A stated manicures for R33 a manicure activity R336 had not atten	p.m. therapeutic recreation I she had in the past provided 6. The last time R336 came to was 3/17/16. TR-A stated ided the manicure activity for and didn't remember the last her fingernails.				
		Veekly Bath Audits sheets 4/24/16, indicated R336 once on 2/8/16.				
	"Grooming/Hygiene 12/11/12, indicated preformed with mo as needed. Care in and females, finger	and Procedure titled e Cares" revision date resident grooming will be rning and evening cares and acluded shaving both males rnails cleaned and manicured. ht nail care will be preformed e.				
	assessment, dated required extensive hygiene. The care a activities of daily liv care plan developm comfort and dignity	linimum Data Set (MDS) I 3/22/16, indicated R18 assistance with personal area assessment, related to ring, indicated to proceed to nent in order to provide r for R18. The care plan, dated R18 was to be clean and well				
	long, dirty fingernai all nails. The obser the time of the obs	3 a.m. R18 was observed with ils with heavy dark soil under vation was verified by RN-D, a ervation. RN-D explained R18 d received 2 baths per week, a	3			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04/29/20	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VALKEF	R METHODIST HEALT	HCENIER	YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 11	2 920			
	facility staff. RN-D scheduled for Wed	bice staff and shower from the verified R18's bath day was Inesdays and nail care would bathing hygiene and daily l.				
	to be completed by Documentation for blank for 4/6/16 an there had been a c since been correct 4/27/16 indicated F stated R18 got a sl and verified the nai	Ith record indicated a bath was the facility on Wednesdays. completion of a bath was d 4/13/16. RN-D explained omputer problem that had ed. The documentation on R18 had refused a bath. RN-D nower on Friday of last week ils could not have grown that RN verified nail care would be a bed bath.				
	"Grooming/Hygiene 12/11/12, indicated performed with mo as needed. Care in and females, finger	and Procedure titled e Cares" with a revision date of residents grooming will be rning and evening cares and acluded shaving both males rnails cleaned and manicured. diabetic, nail care would be ensed nurse.	f			
	The director of nur- all residents in nee hygine to assure th treatment/services and to promote dig director of nursing random audits of t	THOD OF CORRECTION: sing or designee, could review d of assistance with personal ey are receiving the necessary to maintain personal hygiene nified and proper care. The or designee, could conduct he delivery of care; to ensure nd services are implemented.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00276	B. WING		04/29/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE	
WALKEF	R METHODIST HEALT	HCENIER	YANT AVENU POLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21015	Continued From pa	ge 12	21015		
21015	MN Rule 4658.0610 Requirements- Sai) Subp. 7 Dietary Staff nitary conditi	21015		6/8/16
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all			
	by: Based on observati review the facility fa handling procedure	ent is not met as evidenced on, interview and document iled to ensure safe food s were followed in the kitchen ial to affect all 289 residents ir		Corrected.	
	Findings include:				
	a.m. food service w assistant superviso bare hands while m sandwiches. Slices laid out to be closed heating. FSW-C ran the cooler for more to the cooler door, e sliced cheese, and counter. Without ste FSW-C reopened th peeled slices out of laying them on butto prep counter. When stated there was no wiped down at the s When asked specifi washed when comi	he kitchen on 4/27/16, at 11:03 orker (FSW)-C, a cook and r, were observed working with aking multiple grilled cheese of bread and cheese were d up and put in a pan for n out of cheese, and went to . FSW-C grabbed the handle entered to get the package of brought it back to the prep opping for handwashing, he plastic-wrapped cheese, the package, and began ered bread slices sitting on the n about handwashing FSW-C o need to, as the handle got start and end of the shift. ically if hands should be ng back from the cooler to FSW-C said "Yes." FSW-C			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00276	B. WING			04/29/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		23/2010	
		TH CENTER 3737 BF	YANT AVENUE	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21015	Continued From pa	age 13	21015				
	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."						
	revised 7/11/12, ind Members:Will pra	rol Culinary Services policy dicated "Culinary Services Sta actice proper food handling ing but not limited to hand	ff				
	supervisor said, "Y handwashing after	1 a.m. FSW-D, a kitchen és, I would expect to see a kitchen worker goes to the s the handle before resuming					
	The director of nur develop and implet related to provision DON or designee, nursing staff relate The quality assess	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures of care and services. The could provide training for all d the proper care of residents. sment and assurance erform random audits to e.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			6/8/16	
	home must establi	on control program. A nursing sh and maintain an infection esigned to provide a safe and ent.					
	This MN Requirem	nent is not met as evidenced					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04//	29/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
WALKEF	R METHODIST HEALT		YANT AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE	(X5) COMPLET DATE
TAG			IAG	DEFICIENCY		
21375	Continued From pa	age 14	21375			
	review, the facility fail infection control pre-	ion, interview and document ailed to implement effective ocedures during morning care (R176) reviewed on clostridium is precautions.		Corrected.		
	Findings include:					
	4/22/16, revealed t clostridium difficile pressure ulcers. Th having loose stools	itioner (NP) visit notes, dated he following diagnoses: colitis, recurrent UTI, and he NP further noted "Still about 2-3 times per day."				
	ISOLATION" dated on isolation precau	IIS PATIENT IS ON STRICT I 4/12/16, revealed R176 was itions for c-diff beginning precautions had not been				
	(RN)-F and a nursi observed assisting her room. RN-F an shoe covers, gown the room. RN-F wa R176's bottom. RN and donned new gi hygiene, and contin cleaned R176's bor red tinged. NA-A re incontinence briefs them. RN-F was th	5 a.m. the nurse manager ng assistant, (NA)-A were R176 with morning cares in d NA-A were observed to don s and gloves prior to entering as observed to put lotion on I-F then removed her gloves loves, without performing hand nued to assist NA-A. NA-A ttom. Wipes were noted to be eported she needed more a. RN-F reported she would get en observed to remove her				
nnocota D	and leave the room hygiene prior to op room. RN-F was ol gel on her hands a	and gloves, open the door n. RN-F did not perform hand ening the door and leaving bserved to put hand sanitizer t a nearby medication cart. The sanitized after completion of	e			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00276	B. WING		04/	04/29/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
		3737 BB	YANT AVENUE				
NALKEF	R METHODIST HEALT	TH CENTER	POLIS, MN 55				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1		COMPLET DATE	
				DEFICIENC	Y)		
21375	Continued From pa	age 15	21375				
		-					
		ed to room with disposable aring a gown, gloves and foot					
		ed cream to R176's bottom.					
		d her gloves, placed the gloves					
		-F donned new gloves, without					
		nd hygiene. R176 asked for the					
		ed her the phone with gloved					
		the phone. NA-A informed					
		atheter bag was full. RN-F					
		ed cylinder from the bathroom					
	0	as performed or gloves	•				
		ptied the catheter bag into the					
		without first wiping the spigot					
		mptied the cylinder into the					
		gloves and donned new					
		giene was performed betweer	1				
		-F then assisted NA-A with					
		R176. NA-A identified she					
		t mechanical lifts. NA-A					
		, shoe covers and gloves,					
		nd left the room without					
		giene. NA-A returned with a					
		was again wearing a gown,					
		ve shoe covers. RN-F then					
		lows on the bed and assisted					
		e mechanical lift to transfer					
	R176 to the wheeld	hair. NA-A straightened the					
	linen on the bed wh	nile RN-F brushed R176's hair					
	with gloved hands.	RN-F did not perform hand					
	hygiene between p	erforming catheter cares and					
		ransfer and brushing her hair.					
		expressed frustration over a					
		tions and urinary tract					
		mpletion of cares, RN-F					
		hand sanitizer between glove					
		leaving the room. RN-F was					
		e hand sanitizer she used.					
		used the washcloth to clean					
	the spigot of the ca	theter. RN-F reported she					
		d to wash hands only after					

	ta Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00276	B. WING		04/	04/29/2016	
AME OF F	PROVIDER OR SUPPLIEF	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	• •		
ALKEF	R METHODIST HEAL	TH CENTER	YANT AVENUE POLIS, MN 554				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLI DATE	
21375	Continued From p	age 16	21375				
	between glove cha the room to get su was on c-diff preca could be discontin On 4/28/16 at 2:38 (DON) was inform concerns. The DC with facility policy a newly hired. The D	eted and hand sanitizer was ok anges and while briefly leaving upplies. RN-F reported R176 autions but she was hoping the ued soon. B p.m. the director of nursing ed of the infection control NN reported she was unfamiliar and procedure as she was DON reported she would expect nfection control policies and	y				
	4/20/12, directed s A. When providing begin and after an your care 3) Befor removing them 4) body substances s contaminated obje	g/Hand Hygiene policy, dated staff "Handwashing Indications: g resident care 1) Before you y care 2) Between residents in e putting on gloves and after After touching blood or other 5) After touching any potentially ects such as dressings, s, basins, clothing or linen, er and so forth"					
	revised 7/27/12, d "Transmission-bass shed in feces. a. A (such as commod rectal thermometer with feces may se spores. b. C. Diff s patients mainly via contaminated surf Standard Precauti hand washing. 2. I all symptomatic ar when C. Diff is sus	ifficile Infection policy, last irected staff sed precautions 1) C. Diff is Any surface, device or material es, bathing tubs and electrical ers) that becomes contaminated rve as a reservoir for the C. diff spores are transferred to a hands that have touched a ace or item. c. Reinforce ons with high emphasis on Initiate Contact Precautions for nd asymptomatic residents spected or diagnosed. a. Place private rooms. If private rooms					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00276	B. WING		04/	29/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKEF			YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 17	21375			
	cohorted with other infection. b. Use gl room and during re hygiene after remo alcohol does not ki and water is more hand rubs." The Catheter Care 8/1/13, directed sta hand hygiene" and washcloth to wash downward away fro approximately 2-3 Firmly grasp the ca and gently wash th	hese residents can be r residents with C. Diff oves when entering resident's esident care. c. Perform hand wing gloves. d. Because II C. Diff. spores, use of soap efficacious than alcohol-based -Indwelling policy, last revised aff to "wash hands/perform "F. Apply soap to the second the catheter. G. Wiping om urethral opening, cleanse inches of catheter tubing. atheter to prevent tugging on it e tubing. and "4) Gently dry the ve gloves, wash hands"				
	SUGGESTED ME director of nursing educate staff regar handwashing and p transmission. The coordinate audits to performed TIME PERIOD FO	THOD OF CORRECTION: The (DON) or designee, could rding the importance of proper prevention of disease DON or designee, could o ensure proper hadwashing is R CORRECTION: Twenty-one	3			
21426	(21) days. MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			6/8/16
	maintain a compre infection control pro current tuberculosi issued by the Unite	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	HCENTER	YANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
21426	Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of te technical assistance ntation of the guidelines.	21426			
	by: Based on observati review, the facility f tuberculosis (TB) se admission for 1 of s sign/symptom scree upon admission for a Mantoux was rea	ent is not met as evidenced ion, interview and document ailed to ensure a Mantoux for creening was given upon 5 residents (R294), a ening for TB was completed 1 of 5 residents (R591), and d properly upon admission for 590) reviewed for TB		Corrected.		
	screening was not on nursing assessmer R591's Mantoux no administration reco 4/26/16, indicated (Mantoux records TB completed in the admission nt (boxes were left blank) and oted on the medication rd (MAR) when read on (-) but did not note the nillimeters) as guidelines				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WALKEF	R METHODIST HEALT		YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 19	21426			
	admitted to the faci R294's first Mantou to be given on 4/25 given as of the more During interview wi 4/28/16, at 9:12 a.m trained to write in the reading the residen reading was zero. If practice was to give admitted resident with the second given his first Mant that it was late and current nurse work give the Mantoux to R590, who had bee 4/22/16, had a Man 4/23/16, and had no RN-B stated the TE completed by the m admission. RN-B sist screening could no as no boxes were of section in the nursi At 9:52 a.m. RN-D screenings were con the first Mantoux with A few minutes later were completed up nursing admission	th registered nurse (RN)-B on n. RN-B stated nurses were he induration in mm when hts' Mantoux even if the RN-B stated the facility's e the first Mantoux to the newly vithin 24 hours. RN-B stated aware R294 had not yet been oux and verified on the MAR that she would be talking to a ing today and have him or her to R294. RN-B also verified that en admitted to the facility ntoux scheduled to be given on ot been given until 4/25/16. B screening was to be nurse upon the resident's tated while looking at R590 TB t tell if it had been completed checked on the TB screening ng admission assessment.	t 1			
		6 a.m. infection control nurse Mantoux were supposed to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00276	B. WING	B. WING		29/2016
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
VALKEF	R METHODIST HEALT		RYANT AVENUE APOLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 20	21426			
	two after the resider nurses when readin needed to include t just the positive or stated the nursing to monitoring the corr Mantoux and TB so The 2/10/16, policy Tuberculin Skin Tes residents must reco (TB) screening with screening includes resident's risk factor symptoms, and a 2	and were given the first day of ent's admission. IC stated the ing the resident's Mantoux the induration in mm and not negative reading. IC also managers were to be upletion of the two step creening for the residents. It provided by the facility st - Resident indicated "All eive a baseline Tuberculosis in 72 hours of admission. TB an assessment of the prs for TB, any current TB 2-step Mantoux Tuberculin Ski t x-ray, or Quantiferon test as				
	in millimeters the s	olicy also indicated "Documer ize of induration only and the results are positive or	nt			
	The director of nurs develop and impler related to TB testin designee, could pro staff related to TB t assessment and as	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures g procedures. The DON or ovide training for all nursing testing. The quality ssurance committee could udits to ensure compliance.	t			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	9			
21530	MN Rule 4658.131	0 A.B.C Drug Regimen Revie	w 21530			6/8/16
	A. The drug regim	nen of each resident must be				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00276	B. WING		04/29/2016	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
VALKEF	R METHODIST HEALT	TH CENTER	YANT AVENUE POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21530	Continued From pa	age 21	21530			
	currently licensed b This review must b Appendix N of the 3 Surveyor Procedur Requirements in Lo the Department of Health Care Finand This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upon physician visit, or s pharmacist. For pu upon" means the a report and the sign of nursing services C. If the attend with the pharmacis not provide adequa pharmacist believe being adversely aff refer the matter to a if the medical direct physician. If the m the attending physi justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical direct must refer the matter	nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, cing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ubject to frequent change. acist must report any director of nursing services ohysician, and these reports in by the time of the next ooner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ling physician does not concur it's recommendation, or does ate justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality surance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality surance committee.				

STATEMEN	DIT DEPARTMENT OF HE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
WALKE	R METHODIST HEALT	HCENTER	YANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 22	21530			
	This MN Requirem by: Based on observat review the facility fa pharmacist's recon related to orthosta for 1 of 5 residents medication (R535) medications. Findings include: R535 was admitted R535's initial Minim 2/8/16, indicated th antipsychotic media 7-day assessment	ent is not met as evidenced ion, interview and document ailed to ensure the consulting nmendations were acted upon tic blood pressure monitoring on an antipsychotic reviewed for unnecessary d to the facility on 2/3/16. hum Data Set (MDS) dated he resident was prescribed cation (for psychosis) in the period for the diagnosis of ementia. The 2/8/16, MDS also		Corrected.		
	Review of R535's p admission dated 4/ started on an antip 12.5 mg (milligram The physician orde orthostatic blood put three days. Review orthostatic BP's we order was not follow BP's. Review of R535's p indicated to correct Midodrine (increase from hypertension (drop in BP upon ri dated 4/28/16, dire	s also prescribed anti-anxiety medications. bysician orders upon (3/16, indicated R535 had sychotic medication Seroquel s) twice a day for psychosis. er directed staff to check the ressures for R535 daily for of R535's TAR where ere recorded indicated the wed. There were no orthostatic obysician orders dated 4/27/16 t the diagnosis for medications es BP) and Fludrocort (steroid) to orthostatic hypotension sing). The physician order cted staff to take R535's ry month on the 27th.	,			

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	00276	B. WING		04/29/2016	
AME OF PROVIDER OR SUPPL	IER STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
ALKER METHODIST HE		RYANT AVENUE APOLIS, MN 554			
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530 Continued From	n page 23	21530			
Communication recommendation an order for and require the follo of meds: Mon nursing recommendation resident has an Guidelines require category of mean Ortho-BP" Review of an in at 5:00 a.m. R5 his bed. The ind been reaching for the been reaching for On 4/27/16, at for standing alone his walker. R53 11:01 a.m. R53 and unassisted the dining room tab pants and sat of On 4/27/16, at for (RN)-E stated F fallen when he pretty steady. F did not indicate (BP) had been admission to th On 4/27/16, at for stated if a resid	onsulting pharmacist (CP) to Nursing identified a nursing n dated 3/8/16, "This resident ha ipsychotic med. Guidelines wing monitoring for this category hthly or quarterly Ortho-BP" and hendation dated 4/4/16, "This order for antipsychotic med. ire the following monitoring of thi ds: "Monthly or quarterly cident report indicated on 4/9/16, 35 was found on the floor next to ident report stated R535 had or a blanket on his wheelchair. 0:35 a.m. R535 was observed n his room near his recliner with 5 stated he never felt dizzy. At 5 walked down the hall, steady with his wheeled walker toward . At 12:30 p.m. R535 stood by th le with his walker, adjusted his own at the table independently. 11:00 a.m. registered nurse R535 was not a fall risk. R535 ha irst came to the facility but walke N-E also verified R535's record an orthostatic blood pressure aken for R535 since his e facility.	e d			

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00276	B. WING	B. WING		29/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WALKER	METHODIST HEALT		YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 24	21530			
	diagnoses of progr psychosis. R535 has couple of falls after had been doing we was steady on his if pharmacist who wo residents were to h Additionally, an orth fall intervention. RN BP's had not been when falls were rev R535. RN-D waited recommendation. R aware of a recomm orthostatic BP to be verified on R535's record (TAR) that t ordered for 3 days completed. RN-D at two medications fo incorrectly identifies administration record hypotension (drop position). RN-D state On 4/28/16, at 9:50 the NP. The NP has to orthostatic BP's for orthostatic BP's for orthostatic BP's for orthostatic BP's for orthostatic BP's for orthostatic BP's for orthostatic BP was RN-D stated there systolic (the top nu were supposed to b drop of 10 points o On 4/28/16, at 9:50	5 a.m. RN-E stated nothing had				
		early morning report about a for R535. There was also				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
WALKEP	R METHODIST HEALT		YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF			(X5) COMPLETE DATE
21530		-	21530			
	RN-D then stated t evidence of any ca	nour report board about it. here was no progress note nor Il to the NP or physician in BP for R535. RN-D stated o with it.				
	stated she would n related to a BP issu parameters set to o not aware of R535' hypotension or of F RN-E stated R535 but R535 had not h RN-E stated R535 long as he walked	03 a.m. on 4/28/16, RN-E ot call the NP or physician ue unless there were call them. RN-E stated she was s diagnosis of orthostatic R535's previous falls at home. was a fall risk in at admission had any falls in a long time. was now stable on his feet as with his walker. RN-E stated dent with transfers and	5			
	(LPN)-A stated she if a resident's BP d would chart it in a p R535 had hypotens	09 a.m. licensed practical nurse would call the NP or physiciar ropped 8 points or more and progress note. LPN-A stated sion (low BP), and that R535's gh because of the medications	1			
	would call the NP c was less than 100 physician ordered	24 a.m. LPN-B stated she or physician if the systolic BP or if there were NP or parameters. LPN-B stated it t the resident's baseline BP				
	the facility every medications. The C made a recommen monthly or quarterl	09 p.m. the CP said he came to onth to review residents' CP stated on the 3/8/16 visit, he dation to the facility for y orthostatic BP's to be taken stated nurses can make a				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			B. WING			
		00276	D. WING		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
WALKEF	R METHODIST HEALT		YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 26	21530		• /	
	orthostatic BP's. The asked the NP how would write the ord the order the NP has R535 in early Febru taken daily for 3 dat orthostatic BP's ord CP stated he made 3/16. The CP also stated a NP or physe 10-20 point drop in orthostatic BP.	on how often to take the ne CP stated the facility usually often to take them and the NP er. The CP stated he had seer ad written upon admission for uary for orthostatic BP's to be bys. The CP identified the dered had not been done. The e the BP recommendation in stated he had emailed the hursing (IDON) on 4/5/16, that rthostatic BP's taken. The CP sician should be informed of a systolic BP during an	n			
	been the IDON sind a few days ago was nursing (ADON). T to the facility once a residents' medicati typically mailed the within 3 days of his copy of the recomm manager by the ne stated the CP had The ADON stated a manager to schedu TAR and to follow u The ADON also sta recommendation s manager to clarify which time frame (in appropriate for the NP made the decisis nurse would have t significant change	5 p.m. the IDON stated she had ce mid January and now as of s the assistant director of he ADON stated the CP came a month to review all the ons. The ADON stated the CP recommendations to her visit and she gave the hard nendation to each nurse xt business day. The ADON been at the facility on 4/5/16. she expected the nurse ule the orthostatic BP on the up to make sure it was done. ated upon receiving the nursing he would expect the nurse with either the NP or the CP monthly or quarterly) would be resident. The ADON stated the o notify the NP if there was a in the BP when taking an e facility did not follow a	3			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00276	B. WING		04/	04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
WALKER	METHODIST HEALT	HCENTER	ANT AVENUE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21530	Continued From pa	ige 27	21530				
	NP on R535's 18 p because of his nee orthostatic hypoten antipsychotic media were discussed dat managers put the f she was not aware R535's blood press The policy provided Monthly Medication (medication regime the resident's respondent determine that the practicable level of minimizes adverse medication therapy recommendations a nursing and the attac Recommendations documented by the prescriber. The direct licensed nurse will recommendations f	d by the facility dated 10/22/13, a Review indicated "The MRR en review) includes evaluating onse to medication therapy to resident maintains the highest functioning and prevents or consequences related to . Findings and are reported to the director of					
	administrator, direct consulting pharmatic policies and procect medication usage. educated as necess pharmacist's review with the pharmacist	THOD OF CORRECTION: The tor of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be sary to the importance of the v. The DON or designee, along t, could audit medication ar basis to ensure compliance.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		e survey IPleted
		00276	B. WING		- 04/29/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY,	STATE, ZIP CODE		
/ALKEF	R METHODIST HEALT	HCENIER	YANT AVENU APOLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21540	Usage; Monitoring Subp. 2. Monitoring monitor each reside unnecessary drug of home's policies and pharmacist must re- resident's attending physician does not home's recommen- adequate justificati believes the reside adversely affected, matter to the medica director is the medical director physician does not the order and if the change the order, t review to the Quali (QAA) committee r	5 Subp. 2 Unnecessary Drug g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attendin have adequate justification fo e attending physician does not the matter must be referred fo ty Assurance and Assessment equired by part 4658.0070. If iscian is the medical director, rmacist shall refer the matter	f g r t r			6/8/16
	by: Based on observat review the facility fa blood pressure mo	ent is not met as evidenced ion, interview and document ailed to provide orthostatic nitoring for 1 of 5 residents on edication (R535) and reviewed edications.		Corrected.		
	R535's initial Minim	to the facility on 2/3/16. num Data Set (MDS) dated ne resident was prescribed				

STATE FORM

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,			E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
NALKER	METHODIST HEALT	HCENTER	YANT AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	MINNEA ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	POLIS, MN 55	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21540	Continued From pa	age 29	21540			
	7-day assessment non-Alzheimer's de indicated R535 was antidepressant and Review of R535's p admission dated 4/ started on an antip 12.5 mg (milligram The physician orde orthostatic blood pu three days. Review orthostatic BP's we	cation (for psychosis) in the period for the diagnosis of ementia. The 2/8/16, MDS also s also prescribed d anti-anxiety medications. ohysician orders upon '3/16, indicated R535 had sychotic medication Seroquel s) twice a day for psychosis. er directed staff to check the ressures for R535 daily for of R535's TAR where ere recorded indicated the wed. There were no orthostation				
	Review of R535's p indicated to correct Midodrine (increas from hypertension (drop in BP upon ri dated 4/28/16, dire	ohysician orders dated 4/27/16 t the diagnosis for medications es BP) and Fludrocort (steroid to orthostatic hypotension sing). The physician order cted staff to take R535's ry month on the 27th.				
	Communication to recommendation d an order for antipsy require the followin of meds: Monthl nursing recommen resident has an ord Guidelines require	sulting pharmacist (CP) Nursing identified a nursing ated 3/8/16, "This resident has ychotic med. Guidelines g monitoring for this category y or quarterly Ortho-BP" and dation dated 4/4/16, "This der for antipsychotic med. the following monitoring of this "Monthly or quarterly				
	at 5:00 a.m. R535	ent report indicated on 4/9/16, was found on the floor next to ent report stated R535 had				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00276	B. WING		04/29/2016	
JAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		23/2010
	METHODIST HEALT	3737 BB	YANT AVENUE			
		MINNEA	POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21540	Continued From pa	ge 30	21540			
	been reaching for a	blanket on his wheelchair.				
	standing alone in h	a.m. R535 was observed is room near his recliner with ated he never felt dizzy.				
	(RN)-E verified R53 orthostatic blood pr	0 a.m. registered nurse 35's record did not indicate an ressure (BP) had been taken admission to the facility.				
	stated if a resident antipsychotic media	1 a.m. nurse practitioner (NP) was ambulatory and on an cation she recommended ressures be taken monthly for				
	diagnoses of prograpsychosis. R535 has couple of falls after had been doing we pharmacist who we residents were to h RN-D stated that at been discussed at were reviewed as a RN-D waited for the recommendation. F treatment administr orthostatic BP's ord	0 p.m. RN-D stated R535 had essing Parkinson's and ad fallen at home and had a admission to the facility but II lately. RN-D stated it was the ould tell the facility which ave an orthostatic BP taken. In orthostatic BP's had not the daily meeting when falls a fall intervention for R535. CP to make a RN-D verified on R535's 2/16, ration record (TAR) the daily lered for 3 days had not been tated she would follow up.				
	the NP. The NP ha BP's for R535. RN- was taken last even there was a 18 poin top number) BP. R	a.m. RN-D stated she called d ordered monthly orthostatic D stated an orthostatic BP ning for R535. RN-D stated nt drop in R535's systolic (the N-D stated nurses were to the physician or NP a drop				

-	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00276			04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
NALKEF	R METHODIST HEALT	HCENTER	YANT AVENUE			
			POLIS, MN 55	PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 31	21540			
	of 10 points or mor	e in the BP.				
	been passed on in drop in systolic BP nothing on the 24 h RN-D then stated t evidence of any ca	5 a.m. RN-E stated nothing had early morning report about a for R535. There was also nour report board about it. here was no progress note not Il to the NP or physician in BP for R535. RN-D stated o with it.				
	stated she would n related to a BP issu parameters set to o not aware of R535' hypotension or of F RN-E stated R535	03 a.m. on 4/28/16, RN-E ot call the NP or physician ue unless there were call them. RN-E stated she was s diagnosis of orthostatic R535's previous falls at home. was a fall risk in at admission had any falls in a long time.	5			
	(LPN)-A stated she if a resident's BP d would chart it in a p R535 had hypotens	09 a.m. licensed practical nurse would call the NP or physician ropped 8 points or more and progress note. LPN-A stated sion (low BP), and that R535's gh because of the medications	ו			
	would call the NP c was less than 100 physician ordered	24 a.m. LPN-B stated she or physician if the systolic BP or if there were NP or parameters. LPN-B stated it t the resident's baseline BP				
	the facility every me medications. The C made a recommen	09 p.m. the CP said he came to onth to review residents' CP stated on the 3/8/16 visit, he idation to the facility for y orthostatic BP's to be taken				

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
	00276	B. WING		04/	29/2016
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
METHODIST HEALT	HCENTER	-			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ige 32	21540			
clinical judgement of orthostatic BP's. The asked the NP how would write the ord the order the NP has R535 in early Febru taken daily for 3 da orthostatic BP's ord CP stated he made 3/16. The CP also so interim director of m R535 needed an or stated a NP or phys 10-20 point drop in orthostatic BP.	on how often to take the ne CP stated the facility usually often to take them and the NP er. The CP stated he had seen ad written upon admission for uary for orthostatic BP's to be ys. The CP identified the dered had not been done. The the BP recommendation in stated he had emailed the bursing (IDON) on 4/5/16, that thostatic BP's taken. The CP sician should be informed of a systolic BP during an				
nursing (ADON) sta manager to schedu TAR and to follow u The ADON also sta recommendation sl manager to clarify w which time frame (n appropriate for the NP made the deciss nurse would have t significant change i orthostatic BP. The specific guideline o The ADON stated s NP on R535's 18 p because of his nee orthostatic hypoten antipsychotic medic were discussed dat	ated she expected the nurse ile the orthostatic BP on the up to make sure it was done. tted upon receiving the nursing he would expect the nurse with either the NP or the CP monthly or quarterly) would be resident. The ADON stated the ion. The ADON stated the o notify the NP if there was a in the BP when taking an f acility did not follow a f when to call the practitioner. she would have contacted the oint drop in systolic BP ds. He had a diagnosis of sion and was on an cation. The ADON stated falls				
,	ROVIDER OR SUPPLIER METHODIST HEALT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par for R535. The CP s clinical judgement of orthostatic BP's. The asked the NP how would write the ord the order the NP hav R535 in early Febru taken daily for 3 da orthostatic BP's ord CP stated he made 3/16. The CP also s interim director of r R535 needed an or stated a NP or phys 10-20 point drop in orthostatic BP. On 4/28/16, at 1:35 nursing (ADON) sta manager to schedu TAR and to follow u The ADON also sta recommendation sl manager to clarify which time frame (r appropriate for the NP made the decis nurse would have t significant change i orthostatic BP. The specific guideline o The ADON stated s NP on R535's 18 p because of his nee orthostatic hypoten antipsychotic media	00276 STREET ALL METHODIST HEALTH CENTER 3737 BRY MINNEAR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 diag	NEULDING. B. WING BUTING METHODIST HEALTH CENTER STREET ADDRESS, CITY, S STRYANT AVENUE MINNEAPOLIS, MN 55 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 32 Continued From page 32 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 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 NP made the decision. The ADON stated the NP on R535's 18 point drop in systolic BP because of his needs. He had a diagnosis of orthost	DOUDER DEVENDENCE ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 32 21540 Sign anty February for orthostatic BP's to be taken daily for 3 days. The CP stated he had seen the order the NP had written upon admission for RS35 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 3716. The CP also stated he had emailed the interim director of nursing (IDON) on 4/5/16, that RS35 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 sevould expect the nurse manager to clarify with either the	OUZ76 B. WING Out ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55:09 SUMMARY STATEMENT OF DEFICIENCIES (EACH OBRICENOY MUST EN PRECEDED BY FULL RESULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PREOVIDERS PLAN OF CORRECTION (EACH OBRICENOY MUST EN PRECEDED BY FULL PRESIX, The CP stated nurses can make a clinical judgement on how often to take the orthostatic BPS. The CP stated the facility usually asked the NP how often to take the orthostatic BPS. 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 RS35 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 RS35 needed an orthostatic BP's to be taked 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 stated he he donion receiving the nursing recommendation she would expect the nurse manager to clarify with either the NP or the CP which time frame (monthy or quarterly) would be appropriate for the resident. The ADON stated the NP made the decision. The ADON stated the NP made the decision. 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	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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		00276	B. WING		04/	04/29/2016	
AME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
VALKEF	R METHODIST HEALT	HCENTER	YANT AVENUE POLIS, MN 55				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21540	Continued From pa	age 33	21540				
	administrator, direct consulting pharmace policies and procect medication usage. educated as neces pharmacist's review with the pharmacis	THOD OF CORRECTION: The stor of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be sary to the importance of the v. The DON or designee, along t, could audit medication ar basis to ensure compliance.	3				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21670	MN Rule 4658.140	5 A.B.C.D. Resident Units	21670			6/8/16	
	resident: A. A bed of pro convenience of the mattress, and clear weather and reside condition. Each be bedspread. A mois mattress cover mus confined to bed and Rollaway type beds not be used. B. A chair or pl than the bed. C. A place adja personal possessio with a drawer. D. Clean bath often as needed. E. A bed light conv	a must be provided for each oper size and height for the resident, a clean, comfortable of bedding, appropriate for the ent's comfort, that are in good ad must have a clean sture-proof mattress or st be provided for all residents d for other beds as necessary s, cots, or folding beds must ace for the resident to sit other acent or near the bed to store ons, such as a bedside table linens provided daily or more reniently located and of an e needs of the resident while icent chair					

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00276	B. WING		04/2	9/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	H CENTER	ANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21670	Continued From pa	ge 34	21670			
	by: Based on observati failed to ensure bec good repair for 3 of R425, R439) and to stored for use were potential to affect a linens. Findings include: On 4/27/16, at 1:15 dining room after lu the table. A nursing was going to to brin for the afternoon. N assistance of two s (a mechanical full b bed and NA-B cove was a large brown of inches round on top p.m. registered nurs behavior of digging had a bowel moven staff was aware of I smearing feces. During the environn a.m. the following s supervisor (MS), din	ent is not met as evidenced on and interviews the facility d linens were clean and/or in 3 residents observed (R69, o ensure the clean linens in good repair. This had the Il residents who utilized the Il residents who utilized the sistant (NA)-B stated she of R69 to her room to lie down NA-B stated R69 required the taff with the use of a hoyer lift ody lift). R69 was placed in ered her with a blanket. There circular stain approximately 6 of the bed blanket. At 1:39 se (RN)-G stated R69 had the at her buttocks after she has nent (BM). The ADON stated R69's behavior of digging and nental tour on 4/28/16, at 9:05 taff was present, maintenance rector of nursing (DON) and ry supervisor (HS/LS). The		Corrected.		
	1. R69's bed was o sheets tucked in, th and R69's pillow wa	bserved to be made, the le top blanket was pulled up as neatly placed at the head of during the tour, R69's top bed				
Minnesota D STATE FORI	epartment of Health M		6899	1691 11	If continuatio	n sheet 35 of 47

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00276	B. WING	B. WING		29/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VALKEF	R METHODIST HEALT		YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21670	Continued From pa	age 35	21670			
	on 4/27/16. When the fitted sheet was R69's pillow was tur substance was not pillow case. 2. R425's fitted sheet was a state of the second be seen thought and the second be seen that was wore sheets that were were sheets that were were the second be seen placed of the second be sec	eet was so thin the mattress Igh it when held up. n linen closet had one fitted n with a hole in it and two fitted ed on sticky food. nen closet contained fitted				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04/2	29/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKEF	R METHODIST HEALT		YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21670	Continued From pa	age 36	21670			
	through the sheets sheet that was too tossed it to LA-A are to be used. Within than 15 fitted sheet HS/LS explained th vendors and the sh the old vender. He not in good condition The facility's policy	a the dryer. The HS/LS sorted one by one. As he got to a thin, had a hole or a stain he nd informed LA-A they were no a short period of time, more ts were thrown away. The ney had recently changed neets that are worn were from a verified the sheets were thin, on and needed to be replaced. titled "Linens-Clean" dated "clean laundry/bedding is to be				
	handled in a mann microbial contamin handling the linen.'	er that prevents gross lation of the air and persons ' Although requested, no policy lacement was provided.				
	director of nursing educate staff regar clean, functional ar DON or designee, maintenance and h periodic audits of a ensure a safe, clea	THOD OF CORRECTION: The (DON) or designee, could ding the importance of a safe, nd homelike environment. The could coordinate with nousekeeping staff to conduct areas residents frequent to an, functional and homelike intained to the extent possible.	;			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21730	MN Rule 4658.141 Housekeeping, Op	5 Subp. 11 Plant eration, & Maintenance	21730			6/8/16
	condition on the sit conducive to the ha insects, rodents, or	nd rodent control. Any e or in the nursing home arborage or breeding of r other vermin must be ately. A continuous pest				

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(3) DATE SURVEY COMPLETED	
		00276	B. WING		04/29/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	HCENTER	ANT AVENU OLIS, MN 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	
21730	Continued From pa	ige 37	21730			
	control program mu personnel.	ust be maintained by qualified				
		ent is not met as evidenced				
	review the facility fa doors were in good failed to ensure cei insects (ladybugs).	ion, interview and document ailed to ensure residents room repair. In addition the facility ling lights were free from This had the potential to dents on 2 units (1 Rains, 6		Corrected.		
	Findings include:					
	and 4/26/16, with R	ident interviews on 4/25/16 165, R293, R318 and R335 it re resident ceiling lights had gs in them.				
	surveyor "I wish you these bugs," as she ladybugs crawling of tray table. R165 ex of bugs "the other of was a pile of dead	p.m. R165 stated to the u could do something about all e pointed to some live on her floor under her bedside cplained there is an infestation day behind by the video stand ladybugs on the floor." R165 eanliness thing more than				
	a.m. the following s supervisor (MS), di	nental tour on 4/28/16, at 9:05 staff was present, maintenance rector of nursing (DON) and lry supervisor (HS/LS). The d:				
		ghts leading to the dining room ed many dead ladybugs in the				

	DIT DEPARTMENT OF HE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NALKEF	R METHODIST HEALT		YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21730	Continued From pa	age 38	21730			
	room on 1 Rains co ladybugs crawling a fixture where reside	ceiling lights in the dining ontained live and dead along inside the ceiling light ents eat their meals.				
	lights had dead lad					
	doors on the floors scratch marks that	R17, R235, R300, R438, R535 4, 5, and 7 Gamble had long went along the bottom 2/3 of the nicks and large gouges of the doors.				
	5. R235's bathroon missing approxima	n door was scratched up and tely half the paint.				
	I moved in [1/27/15 hit the door." The c	is door has been like this since [] I go straight in/out and do no door was observed to have the length of her door with 3 e side of her door.				
	live and dead bugs were ladybugs. All residents should no or in their rooms ar explained he was a throughout the faci pest control compa control the ladybug vacuuming them up verified that dining	sent during the tour verified the in the ceiling light fixtures three staff presents verified of have to look up while eating nd see dead bugs. The HS/LS aware of the ladybug issues lity. HS/LS verified the facility any did not have any solution to s other than his staff p when needed. HS/LS room ceiling light on 1 Rains taken care of right away.				
	doors were not in g need of repairs. Th	sent during the tour verified the good conditions and were in ne MS explained if staff or ue they would fill out a work	9			

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04/	29/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WALKEF	R METHODIST HEALT		YANT AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21730	Continued From pa	age 39	21730			
	desk know. Mainte the concern. The M preventive mainten related to cleaning and more mechani explained any door taken off and sand had not received at repair. The MS exp things that needed through of a couple further indicated th floors were toured but that was no lon identify the last time through nor which the A review of the faci Adams pest contro "Customer pest sig and 4/26/16 ladybut and the conference The service date by 11/9/15, and indica	ility's pest control book from I, Inc. indicated under Ihting," on 10/13/15, 4/21/16 Igs were seen on 4 gamble e room by the dental office. If Adams pest control Inc. was ted action taken was exterior and using vacuum for interior	f			
		have a policy or procedure for				
	director of nursing educate staff regar maitaining an effect DON or designee, maintenance and h periodic audits of a	THOD OF CORRECTION: The (DON) or designee, could rding the importance of stive pest control program. The could coordinate with nousekeeping staff to conduct ureas residents frequent to pest debris is controlled to				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY IPLETED	
		00276	B. WING		04/29/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VALKER	R METHODIST HEALT	TH CENTER	YANT AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21730	Continued From pa	age 40	21730			
	environment is mai	intained to the extent possible.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			6/8/16
	residents shall, at a are legal rights for stay at the facility o treatment and main that these are desc written statement o responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and org advocacy and legal residential program accommodations s communication imp speak a language of facility policies, insp local health authori the written statement to patients, resident chosen representation person, consistent	ation about rights. Patients and admission, be told that there their protection during their or throughout their course of ntenance in the community and cribed in an accompanying of the applicable rights and forth in this section. In the limitted to residential programs on 253C.01, the written o describe the right of a d or older to request release a 253B.04, subdivision 2, and s and telephone numbers of anizations that provide I services for patients in ns. Reasonable shall be made for those with patient than English. Current pection findings of state and ties, and further explanation o ent of rights shall be available its, their guardians or their tives upon reasonable request r or other designated staff with chapter 13, the Data section 626.557, relating to	d s			

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04/	29/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
/ALKER	METHODIST HEALT	HCENTER				
			POLIS, MN	PROVIDER'S PLAN OF C		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	age 41	21800			
	by: Based on interview facility failed to pro- rights notice in a tir termination of Med	ent is not met as evidenced and document review, the vide proper liability and appeal mely manner prior to the icare skilled services for 2 of 3 493) reviewed for liability ary appeal rights.		Corrected.		
	Findings include:					
	beneficiary appeal 4/27/16, the followi R247's medical rec Notice of Medicare (NMPNC) on 4/27/ forms NMPNC that recipients at least 4 their Medicare cove the social service of summary dated 12 PT, OT and speech	cord was reviewed for the Provider Non-Coverage forms 16. The medical lacked the twere to be signed by 48 hours prior to the end of erage in the facility. However discharge and recapitulation /6/15 read, "resident received in therapies along with skilled Resident to discharge home	5			
	stated, the Skilled I Beneficiary Notice Non-Coverage sho before covered ser R247 was discharg voluntarily wanted i R247 was on and o mentioned, "I did n	8 a.m. registered nurse (RN)-A Nursing Facility Advance and the Notice of Medicare suld be given at least two days vices would end. RN-A stated ge prior to the 90 days and to go home on day 89 and off therapy. In addition, RN-A ot give the liability and appeal se of that. Otherwise, I would hours notices."				
	R493's medical rec					

STATEMEN	DT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		04/	29/2016
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE	04/	29/2010
		3737 BBY	ANT AVENUE			
WALKER	R METHODIST HEALT	MINNEAF	POLIS, MN 55	5409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21800	Continued From pa	age 42	21800			
	that were to be sign hours prior to the e in the facility. Howe discharge and reca 12/3/15, read "Date 12/3/15. Communit information: Reside	he record lacked the forms ned by recipients at least 48 and of their Medicare coverage ever the social service apitulation summary dated e discharge order received: ty resources/addition ent to d/c [discharge] to sisted living facility] with				
	Nursing Facility Ad the Notice of Medic given at least two c would end. R493 w 17 days and discha assisted living. Fur did not give the liab because of that. Of	7 a.m. RN-A stated the Skilled vance Beneficiary Notice and care Non-Coverage should be lays before covered services vas admitted to the facility for arged choosing to go to an thermore, RN-A declared, "I bility and appeal rights notice therwise, I would have given e 48 hours window."				
	medical record lack Advance Beneficia Medicare Non-Cov stated the resident until a denial letter stated her expectat	8 a.m. RN-A confirmed, the ked Skilled Nursing Facility ry Notice and the Notice of erage for R247 and R493 and would have remained skilled was issued. RN-A further tion was a letter was to be ent within 48 hours of y skilled services.				
	(rehab) director ver records for for R24 be discharged. The discharge planning family as needed a Medicare nurse an	6 a.m. the rehabilitation rified, the rehab medical 7 and R493 lacked requests to e director added, "We do a meeting with resident and and give a 48 hour notice to the d the rest of the IDT am] prior to discharge. In				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00276	B. WING		04/	29/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
WALKEF	R METHODIST HEALT	HCENTER	ANT AVENUE OLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	age 43	21800			
	absence of formal are notified by the t	meetings, resident and family therapist."				
	MEDICARE/MEDIC read, "Individuals re re-evaluated on a r Medicare coordinat coverage based on when it is determine requires a Medicare notify the resident of hours prior to the c resident or financia agree with this deci-	procedure titled NOTICE OF CAID BENEFITS dated 2014, eceiving Medicare benefits are egular basis by the facility's for to determine continued in the daily skilled need. If and ed the resident no longer e skilled service, the facility will or responsible party at least 48 hange in payer source. If the illy responsible party does not ision, you will be given the to request a demand bill. This blained in full at the time of the benefits."				
	The director of nurs review and revise p to provision of notic ended. The directo develop a system to monitoring system	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related ce when skilled services have or of nursing or designee could o educate staff and develop a to ensure compliance. R CORRECTION: Twenty-one				
21810		.651 Subd. 6 Patients &	21810			6/8/16
	residents shall have medical and person needs. Appropriate care designed to en	ac.Bill of Rights riate health care. Patients and e the right to appropriate nal care based on individual e care for residents means nable residents to achieve their vsical and mental functioning.				

Minneso	ta Department of He	alth			101107	
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00276	B. WING		04/2	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
WALKEF	R METHODIST HEALT	HCENTER	YANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 44	21810			
		where the service is not blic or private resources.				
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document ailed to ensure call lights were for 1 of 1 resident (R335).		Corrected.		
	Findings include:					
	resident was seated the bed was pushed call light was out of from the call light be above the bed. R33 never in reach. It's the wall where I car	d on 4/25/16, at 3:22 p.m. The d in a wheelchair. One side of d up against the wall. R335's her reach and hung down ox approximately 18 inches 85 reported, "The call light is always in that position along n't reach it." R335 explained if he would have to yell for staff				
	was out of her reac light box where the the wall. R335 said until someone com- then requested "ple bed" so she could r family member (FM	a.m. R335's call light again h as it was clipped to the call bed was pushed up against , "I guess I would have to wait es along [to get help]." R335 ease clip the call light to the reach it. At 4:15 p.m. R335's I)-A was visiting the resident ther's call light is rarely in				
	observed out of her her wheelchair. The floor next to the bee to reach the call ligh	a.m. R335's call light was reach. R335 was seated in call light was lying on the d. When asked if she was able ht she replied, "No. It's on the				
Minnesota D STATE FORI	epartment of Health M		6899	1691 11	If continuatio	n sheet 45 of 47

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00276	B. WING		04/29/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WALKEF	R METHODIST HEALT	H(FNIER	YANT AVENUE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	age 45	21810			
	floor and I'm in my	wheelchair."				
	had macular deger one eye, and the re Staff was directed if within her reach at where to find the lig resident to use the plan noted the resid with transfers, bed On 4/27/16, at 9:50 reported she was a the day, and was fa requirements. NA-0 noted on the floor a able to reach it sho On 4/27/16, at 10:0 nursing (ADON) ex residents would ha even if the resident In addition, the AD0 ensure call lights w at all times.	ated 1/21/14, indicated R335 heration causing blindness in esident was at risk for falls. to ensure R335's call light was all times, inform the resident ght, and to encourage the light to call for help. The care dent required staff assistance mobility, and ambulation. 0 a.m. nursing assistant (NA)-O assigned to care for R335 for amiliar with the her care C verified R335's call light was and she would not have been buld she need to summon help 07 a.m. the assistant director o explained she expected all ve their call lights within reach t was unable to utilize the light. ON explained staff should vere within the residents' reach	f			
	provided.	t was requested, but was not				
	director of nursing educate staff regar environment. The coordinate with sta	THOD OF CORRECTION: The (DON) or designee, could ding the importance of a safe DON or designee, could ff to conduct periodic audits of quent to ensure a call lights				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health									
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:			(X3) DATE SURVEY COMPLETED			
		00276		B. WING		04/2	9/2016		
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
WALKEF	R METHODIST HEALT	HCENTER		ANT AVENU OLIS, MN 5					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
Minnesota D	epartment of Health								