



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 3, 2025

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: CCN: 245618
Cycle Start Date: January 23, 2025

Dear Administrator:

On January 23, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 23, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by July 23, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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February 3, 2025

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: State Nursing Home Licensing Orders
Event ID: J34I11

Dear Administrator:

The above facility was surveyed on January 21, 2025 through January 23, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 02/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245618	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/23/2025
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II			STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 1/21/25-1/23/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 1/21/25-1/23/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints was reviewed with no deficiency issued. - H56183582C (MN00109394) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/13/2025

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

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F 000	Continued From page 1	F 000			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident choices for bathing preferences were assessed and honored for 1 of 1 residents (R5) reviewed for choices.	F 561			3/4/25
			Resident 5 interviewed regarding bathing preferences. The resident's care plan and Kardex reviewed and updated based on his preference for shower vs bed bath.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 561	Continued From page 2 Findings include: R5's admission Minimum Data Set (MDS), dated 1/6/25, indicated R5 had intact cognition with no hallucinations or delusions. On 1/21/25 at 8:57 a.m., R5 indicated he has only been out of bed one time since admission to the facility. R5 indicated he was transferred out of bed with assist of 2 staff and walker and back to bed with a Hoyer lift (mechanical lift/device that lifts patients from one place to another who cannot bear weight on their lower extremities). R5 indicated he was currently receiving hospice services. R5 indicated staff come in and "wash me up and rotate me" but has not had a shower since admission which he prefers. R5's care plan, printed 1/23/25, identified the following: - "BATHING/SHOWERING: The resident requires assistance from 1 staff with bathing." - "TRANSFER: The resident is totally dependent on staff for transferring." - "PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on staff for personal hygiene and oral care." - "The resident is WEIGHT-BEARING." - "AMBULATION: The resident does not ambulate." R5's care plan lacked evidence of R5's preference to have a shower versus a bed bath. R5's care sheet, printed 1/21/25, lacked evidence of preference of bathing preferences: showers vs baths. R5's Kardex, printed 1/21/25, identified the			F 561	All residents have the potential to be affected. Facility audit performed to ensure that residents' choices are being honored for bathing preferences. Care Plans policy reviewed and updated. Nursing staff educated to provide cares to residents that honor resident preferences. Social services or designee will interview 5 random residents weekly x 4 weeks to ensure resident choices are being honored for bathing preferences. Results of the audits will be reviewed with the QAPI committee. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 561	Continued From page 3 following: - "Bladder/Bowel: Encourage resident to sit on toilet to evacuate bowels if possible." - "Toileting: Ensure resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible." - "BATHING/SHOWERING: The resident requires assistance from 1 staff with bathing." - "TRANSFER: The resident is totally dependent on staff for transferring." - "PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on staff for personal hygiene and oral care." R5's Kardex lacked evidence of R5's preference to have a shower versus a bed bath. R5's progress notes, dated 12/31/25 to 1/23/25, were reviewed. R5's progress notes lacked evidence of an assessment or conversation of R5's choice for bathing preference. R5's Nursing Assessment Admission/Readmission, dated 12/31/25 was reviewed and identified the following: - "Bathing Preference/Day/Shift" marked "ADL-Bathing Monday and Thursday PM" R5's Nursing Assessment lacked evidence of assessment of R5 being offered a choice between a bed bath and shower. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and Kardex's to find the information needed to care for residents. NA-A indicated if they had any questions about resident cares/needs, they would ask the nurse. NA-A verified there was important information on the			F 561			

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F 561	Continued From page 4 care sheets such as residents name, bath days, how they transfer, if they are continent or incontinent of bowel and bladder and other health information. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 requires staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week. NA-C verified they have not assisted R5 with a shower, adding "hospice has been doing his bed baths," and verified showering was a responsibility of nursing assistants. NA-C was unable to indicate whether R5 preferred a bed bath or a shower. NA-C stated the care plan indicates that R5 needs assist of 1 staff. On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D indicated they have not transferred R5 "for a while" and were unable to give a time frame of the last time they assisted. NA-D indicated they "think he is a Hoyer". NA-D indicated they are not sure when hospice comes to see R5 and stated, "there is a schedule for hospice I think." NA-D indicated they have not assisted R5 with a shower. During a follow up interview on 1/22/25 at 2:50 p.m., R5 verified they prefer a shower. R5 stated he has not been offered a shower since admission. R5 added he doesn't know if there was a shower in the bathroom as he has not been in the bathroom in his room before. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated this would be added to the care plan. RN-B stated that if a resident has a preference to have	F 561			

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F 561	Continued From page 5 a bed bath versus a shower, that would have been assessed and added to the care plan for continuity of care. RN-B verified R5 was on hospice. On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care sheets, care plans, Kardex to help determine resident needs. NA-B stated if they had questions about resident needs, they would ask the nurse. NA-B stated if it was resident's preference to have a bed bath versus a shower, that would be on the care plan and stated, "an aid cannot decide this." NA-B stated an aide's job is to "help the resident, wash the resident if needed, change the resident, you make beds, give them the call lights." NA-B stated residents' preferences would be on their care plan such as if they prefer to stay in bed or if they want a bed bath or a shower. On 1/23/25 at 10:08 a.m., licenses practical nurse coordinator (LPN)-C indicated residents should be given choices regarding their cares and their preferences are put on their care plans. LPN-C reviewed R5's assessments and care plan. LPN-C verified R5's electronic medical record (EMR) lacked evidence R5 was provided choices regarding showers versus baths. Furthermore, LPN-C verified R5's care plan indicates R5 was able to bear weight and dependent on staff for transferring. LPN-C verified R5 was not assessed by physical therapy or occupational therapy as "[R5] is on hospice." LPN-C stated it is important that residents have choices as, "it is their right to make choices ...we are taking care of them ...we want to meet their needs and provide the best care we want to accommodate that to the best of our ability."	F 561			

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F 561	Continued From page 6 On 1/23/25 at 12:15 p.m., director of nursing (DON) verified a resident should be assessed for preferences and the preferences would be on a resident's care plan. DON verified if a resident has a preference to have a shower or a bed bath, that would be on a care plan as that would have been assessed.	F 561			
F 582 SS=D	A facility policy on resident choices was requested and not received. Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582			3/4/25

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F 582	Continued From page 7 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and/or Notice of Medicare Non-Coverage (NOMNOC; CMS-10123) upon the termination of Medicare A coverage for 3 of 4 residents (R26, R187, and R188) reviewed. Findings include: R26's Census Record, printed 1/23/25, identified on 1/15/25, R26's payor source changed. The			F 582	R26, R187, and R188 have been discharged from the facility. Billing has reviewed these resident's billing to ensure that residents were charged for services appropriately. Social services department is providing Skilled Nursing Facility Advanced Beneficiary Notice and /or Notice of Medicare Non-Coverage upon the termination of Medicare A coverage as required. All current residents who are utilizing or		

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F 582	Continued From page 8 record further indicated R26 remained in the facility. R26's Centers for Medicare and Medicaid Services (CMS)-10123 signed as received on 1/10/25, identified a last covered day (LCD) of 1/14/25, when R26's Medicare coverage would end. R26's Centers for Medicare and Medicaid Services (CMS)-R-131 signed as received on 1/21/25 which was 6 days after private pay costs started and after survey entrance. R187's Census Record, printed 1/23/25, identified on 10/15/24, R187's payor source changed. The record further indicated R187's billing stopped on 10/16/24. R187's Centers for Medicare and Medicaid Services (CMS)-10123 signed as received on 10/11/25, identified a last covered day (LCD) of 10/14/24, when R187's Medicare coverage would end. R187's medical record was reviewed and lacked any evidence a SNFABN had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. R188's Census Record, printed 1/23/25, identified on 8/5/24, R188's payor source changed. The record further indicated R188's billing stopped on 8/7/24. R188's medical record was reviewed and lacked any evidence a SNFABN or NOMNOC had been			F 582	have utilized Medicare A during their stay at facility audited to ensure that applicable NOMNC or SNFABN forms have been issued appropriately. All residents nearing the end of their Medicare A coverage will be reviewed by the Social Services and Administration departments to ensure that all required notices are provided regarding termination of Medicare A coverage. Beneficiary Notices policy reviewed and remains current. Social services educated on indications of when and how to issue NOMNC and SNFABNs accurately and timely. Administrator or designee will audit 3 random residents who are nearing the end of Medicare A coverage weekly x 4 weeks to ensure that applicable NOMNCs and SNFABNs have been provided if applicable. Results of the audits will be reviewed with the QAPI committee. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 582	Continued From page 9 provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. On 1/23/25 at 11:27 a.m., administrator verified R26 had received a NOMNOC but did not receive a SNFABN until after payor source had started and after survey entrance. Administrator verified R187 received a NOMNOC but did not receive a SNFABN and should have. Furthermore, administrator verified R188 did not receive a SNFABN or NOMNOC and should have. Administrator stated retraining has been provided regarding notices as it was discovered that "some things weren't getting done." Administrator stated they are currently reviewing NOMNOC's and SNFABN's to ensure accuracy. A facility policy titled Beneficiary Notices, revised 1/2025, indicated the facility will "inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate."			F 582			
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,			F 583			3/4/25

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F 583	Continued From page 10 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure private and confidential resident information was secure and not visible to residents and visitors when multiple care sheets were left out in public view. This had the ability to affect eleven residents on the 400 hallway including R4. Findings include: During observation on 1/21/25 at 12:17 p.m., a medication cart down the 400 hallway was left			F 583	Care sheets with resident information found in public view were removed from public areas. Audit conducted of the TCU and public areas to ensure no further privacy concerns. Notice of Privacy Practices policy was reviewed and remains current. Staff who handle resident's personal information		

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F 583	Continued From page 11 unattended with a care sheet out in public view which identified five patient rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. Multiple residents were seen wandering by the unattended medication cart with resident private information in sight. During an interview on 1/21/25 at 12:27 p.m., registered nurse (RN)-D stated he was working from the medication cart that day and due to the private resident information on the care sheets, they should be tucked away under the computer or behind the nursing desk so it was not out and visible to residents or visitors. During observation on 1/21/25 at 9:48 a.m., a clip board was observed sitting on the edge of the unit desk with a care sheet "cart 1" out in public view which identified five resident rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. Multiple residents and family members were seen wandering by the unattended clip board with resident private information in sight. At 9:53 a.m., registered nurse (RN)-E was observed to pick up the clip board that contained the care sheet. On 1/23/25 at 8:22 a.m., it was observed	F 583	re-educated on the importance of protecting residents' personal information and properly securing residents' personal info. Administrator or designee will complete audits of the TCU and public areas ensuring resident privacy and confidentiality of records 3x weekly for 4 weeks. Results of the audits will be reviewed with the QAPI committee. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 583	Continued From page 12 medication cart 3 was left unattended in the hallway outside a room with the computer screen open with R4's medication orders on the screen along with a care sheet out in public view. The care sheet labeled "cart 3" identified six resident rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. There was no nurse in the area. At 8:25 a.m., licensed practical nurse (LPN)-A came out of a resident room stating, "Oh my, did I leave that open?" when asked about the computer screen. LPN-A verified the screen was left open and unattended with resident information viewable and verified they were working on medication cart 3. LPN-A grabbed the care sheet when asked to verify what the sheet was titled and placed it in their pocket stating, "it is always in my pocket." LPN-A verified the sheet had resident information on it. On 1/23/25 at 10:30 a.m., licensed practical nurse coordinator (LPN)-C stated it is important to keep resident information private. LPN-C stated the expectation was that resident information is not to be left out in public view and any papers are to be flipped over and computer screens should be locked when not in use. A facility policy titled Notice of Privacy Practices, revised 1/2025, indicated "we are required by law to maintain the privacy and security of your protected health information."	F 583			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655			3/4/25

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F 655	Continued From page 13 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655			

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F 655	Continued From page 14 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide a copy of the resident's base line care plan for 1 of 2 resident (R26) reviewed for baseline care plans. Findings include: R26's admission Minimal Data Set (MDS), dated 12/16/24, indicated R26 was admitted to the care facility on 12/10/24 and was cognitively intact. R4's Care Conference Summary, dated 12/22/24, contained a section for comment that stated, "copies of care plan given/sent". In the text box was typed "N/A [not applicable]". During an interview on 1/22/25 at 1:51 p.m., R26 stated she had attended a care conference since she arrived at the care facility but had not received a copy of her care plan, stating "I would like to see it and have a copy if possible." During an interview on 1/22/25 at 12:10 p.m., social services (SW)-A stated there process was to start the baseline care plan the day a resident was admitted but they did not provide a copy of the care plan to residents or their representatives until they discharged. During an interview on 1/22/25 at 11:00 a.m., the nurse coordinator (NC) and director of nursing (DON) confirmed their process was to give	F 655	R26 has discharged from the facility. R26 was provided a copy of care plan prior to discharge. All residents have the potential to be affected. Audit conducted to ensure that all residents have received a copy of their baseline care plan. Care Plans policy reviewed and updated. Licensed nurses and social services educated on requirement to provide baseline care plans to residents or their representatives. Education included how to generate and print baseline care plans. Social services or designee will audit 5 random residents weekly x 4 weeks to ensure baseline care plans are being provided to residents. Results of the audits will be reviewed with the QAPI committee. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 655	Continued From page 15 resident a copy of their care plan on discharge along with a recapitulation of stay. A facility policy titled Care Plans, revised 1/2025, indicated "the facility will provide the resident and their representative, if applicable, with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary must be in a language and conveyed in a manner the resident and/or representative can understand."	F 655			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656			3/4/25

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F 656	Continued From page 16 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate care was provided for 1 of 5 residents (R29) reviewed for comprehensive care plan. Findings include: R5's admission Minimum Data Set (MDS), dated 1/6/25, indicated R5 was admitted on 12/31/24, had intact cognition and required maximum assistance for oral hygiene, toileting, dressing lower part of body, footwear, personal hygiene, bed mobility, and transfers. R5 required touching assistance for upper body dressing. Noted for tub/shower transfer, not applicable. R5's MDS indicated no behaviors were present, and no	F 656	R29 has been discharged from the facility. All residents who reside at the facility for 21 days are having a comprehensive care plan developed and maintained to ensure appropriate care. All residents who have resided at the facility for 21 days have been audited to ensure a comprehensive care plan was developed and maintained. Care plan policy reviewed and updated. Licensed nurses and interdisciplinary team educated on care plan policy of what to include in comprehensive care plan. DON or designee will audit 3 random care		

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F 656	Continued From page 17 rejection of care exhibited. Section H: Bladder and Bowel indicating R5's always continent of bowel. Section V: Care Area Assessment (CAA) summary, the following care areas were triggered and marked as addressed in care plan: communication; ADL function/rehabilitation potential; urinary incontinence and indwelling catheter; falls; nutritional status; dental care; pressure ulcer and psychotropic drug use. R5's diagnosis report, printed 1/23/25, included the following diagnoses: acute kidney failure (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few day), retention of urine (condition where the bladder doesn't empty completely), diabetes (condition that affects your blood sugar levels), anemia (body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), Atrial fibrillation (an irregular and often rapid heart rhythm that can lead to stroke and heart failure), congestive heart failure (heart not pumping pump properly), hypertension (high blood pressure), depression, obstructive sleep apnea (sleep disorder characterized by episodes of a complete or partial collapse of the airway with an associated decrease in oxygen saturation or arousal from sleep), ischemic cardiomyopathy (a condition of weakened heart muscles due to heart attack or coronary heart disease), and chronic kidney disease (a condition in which the kidneys are damaged and can't filter blood as well as they should). R5's Order Summary Report, dated 1/22/25, indicated the following orders: - hospice referral on 12/31/24. -Apixaban (used to prevent stroke and blood	F 656	plans of residents who have resided at the facility for 21 days weekly x 4 weeks to ensure comprehensive care plans are developed and maintained. Results of the audits will be reviewed with the QAPI committee. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 656	Continued From page 18 clots) 5 milligrams (mg) tablet; give 2.5 mg by mouth two times a day for CVA [cerebral vascular accident], stroke started 12/31/24 -Gabapentin (anti-convulsant medication which can be used to treat nerve pain) 300 mg capsule; give 1 capsule by mouth one time a day for neuropathic pain [order entered twice for two different times during the day] started 12/31/24 -Gabapentin 300 mg capsule; give 2 capsules by mouth at bedtime for neuropathic pain started 12/31/24 -haloperidol (antipsychotic medication) tablet 1 mg; give 1 tablet by mouth every 4 hours as needed for nausea/vomiting -Hydromorphone (opioid pain medication) HCL 2 mg tablet; give 1 mg by mouth every 4 hours as needed for pain, dyspnea (shortness of breath) started 12/31/24 -mirtazapine 15 mg tablet; give 0.5 tablet by mouth at bedtime for MDD (major depressive disorder) started 12/31/24 R5's care plan, printed 1/23/25, identified the following: - "Resident has potential/actual risk of abuse from (self/others) to admission" with no goal or interventions listed. - "The resident has an ADL self-care performance deficit" with no goal listed the following interventions: - "Mobility/Safety/Medical Devices: (Examples: TLSE, Splint, Brace, Walker, Wheelchair, Oxygen, Wound Vac, etc). " - "Bed Mobility: The resident is totally dependent on staff for repositioning and turning in bed (SPECIFY FREQ) and as necessary." - "The resident has constipation r/t [related to]" with a goal and interventions. - "The resident is on anticoagulant therapy r/t"	F 656			

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F 656	Continued From page 19 with a goal and interventions. - "The resident is on pain medication therapy r/t" with a goal and interventions. - "The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for pressure ulcer development r/t" with a no goal listed with three interventions. - "The resident has potential/actual impairment to skin integrity of (SPECIFY location) r/t" with no goal listed with three interventions. R5's care plan lacked evidence of the following areas being identified in the care plan after identified being in the CAA: communication, urinary incontinence and indwelling catheter, falls, psychotropic drug use. R5's care plan lacked evidence of R5's cognitive abilities, behavioral symptoms, resident specifics regarding mobility/safety/medical devices (what medical devices R5 utilizes), resident specific how frequent resident should be repositioned and turned in bed, resident specific pressure ulcer concerns, resident specific skin integrity concerns, specifics relating to pain/anticoagulant/constipation. Furthermore, the care plan lacked any coordination with hospice or discharge plan. Additionally, R5's care plan lacked a goal for focus areas for: - "Resident has potential/actual risk of abuse from (self/others) to admission" - "The resident has an ADL self-care performance deficit" - "The resident has limited physical mobility" - "The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for pressure ulcer development r/t"	F 656			

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F 656	Continued From page 20 - "The resident has potential/actual impairment to skin integrity of (SPECIFY location) r/t" In addition, R5's care plan lacked any interventions for the focus area of - "Resident has potential/actual risk of abuse from (self/others) to admission" Additionally, R5's care plan lacked evidence of R5's preference of a shower versus a bed. R 5' s' care plan lacked evidence of R5's specific needs to transfer (assist of 2 staff, or Hoyer lift). Additionally, R5's care plan lacked evidence of R5's preference to use the bathroom vs incontinent pad and need for Foley catheter. R5's care plan lacked evidence of R5's preferences for therapeutic activities. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and Kardex's to find the information needed to care for residents. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 needs staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week, adding "we go in and reposition him." NA-C stated R5's incontinent pad is check and changed when R5's repositioned, verifying R5 has not been offered a bed pan, use of the bathroom or toilet. NA-C was unable to indicate whether a bed bath was NA-C preference versus a shower. NA-C verified R5 had a catheter upon admission to the facility. On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D verified they do not offer	F 656			

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F 656	Continued From page 21 R5 a bed pan, or toilet as R5 was to be repositioned and changed. NA-D indicated they have not transferred R5 "for a while" and were unable to give a time frame of the last time they assisted. NA-D indicated they "think he is a Hoyer". NA-D indicated they are not unsure when hospice comes to see R5 and stated, "there is a schedule for hospice I think." NA-D verified nursing assistants use Kardex and care sheets to know resident needs. During a follow up interview on 1/22/25 at 2:50 p.m., R5 stated he prefers a shower vs a bed bath. Furthermore, R5 stated he prefers to use bathroom vs an incontinent pad. R5 verified he has a Foley catheter. R5 stated his spouse (who resides in a separate part of facility) visits daily, enjoys listening to music and likes to watch TV. R5 stated he enjoys watching football. R5 stated he doesn't know if he is going to discharge from facility but would like to stay with his spouse but doesn't know if that is possible. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated preferences would be added to the care plan. RN-B stated that if a resident has a preference to have a bed bath vs a shower, that would have been assessed and added to the care plan for continuity of care. RN-B verified R5's current plan as of 1/22/25 and lacked items listed above. On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care plans, care sheets, and Kardex's to help determine resident needs. NA-B stated residents' preferences would be on their care plan such as if a resident preferred a bed	F 656			

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F 656	Continued From page 22 bath vs a shower. On 1/23/25 at 10:08 a.m., licenses practical nurse (LPN)-C nurse coordinator indicated a comprehensive care plan should include all activities of daily (ADL) needs (transferring, dressing, ambulating, etc.), any wounds or potential skin issues, antibiotics and dependent on the resident. LPN-C indicated the entire team, including social services adds to the care plan. LPN-C verified hospice information included hospice contact information, hospice goals should be on the comprehensive care plan. LPN-C verified resident preferences should be on the comprehensive care plan such as if a resident prefers a bed bath vs a shower or if a resident prefers to stay in bed vs getting out of bed. LPN-C verified the comprehensive care plan needs to be specific to each resident and all areas need to be completed to be resident specific. LPN-C verified R5's care plan lacks hospice information, preferences with shower vs bed bath, responsibility of R5's showers. LPN-C verified R5's care plan was not comprehensive or resident specific. On 1/23/25 at 12:15 p.m., director of nursing (DON) stated a comprehensive care plan needs to be completed by day 21 after admission. DON verified the comprehensive care plan needs to be resident specific and would include treatments, preferences, hospice information, diagnosis and other pertinent information. DON stated the comprehensive care plan needs to be resident focused. A facility policy titled Care plans, dated 1/2025, indicated "the comprehensive care plan must	F 656			

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F 656	Continued From page 23	F 656			
F 657 SS=D	describe the following: services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being ..." Furthermore, "the comprehensive care plan must reflect interventions, the specific care and services that will be implemented, to enable each resident to meet his/her objectives." Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657			3/4/25

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F 657	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure care conferences were conducted upon admission for 1 of 2 residents (R5) reviewed for care conferences. Findings include: R5's admission Minimum Data Set (MDS), dated 1/6/25, indicated R5 had intact cognition with no hallucinations or delusions with an admission date of 12/31/24. Diagnoses included: heart failure, hypertension (high blood pressure), diabetes (condition that affects your blood sugar levels), depression, obstructive sleep apnea (sleep disorder characterized by episodes of a complete or partial collapse of the airway with an associated decrease in oxygen saturation or arousal from sleep), ischemic cardiomyopathy (a condition of weakened heart muscles due to heart attack or coronary heart disease), and chronic kidney disease (a condition in which the kidneys are damages and can't filter blood as well as they should). R5's progress notes, dated 12/31/24 to 1/23/25, were reviewed. Progress notes lacked evidence of R5 having a care conference since admission on 12/31/24. Furthermore, lacked documentation of planning a care conference. R5's assessment tab in the electronic medical record (EMR), dated 12/31/24 to 1/23/25, were reviewed for care conference note. Assessment for care conference lacked evidence of R5 having a care conference since admission on 12/31/24. On 1/21/25 at 8:57 a.m., R5 was observed lying			F 657	R5 had a care conference to discuss plan of care on 01/27/25. Referral sent to long term care placement community of resident's choice on 01/27/25. Resident will transition to long term care placement community upon next opening. All residents have the potential to be affected. All residents audited to ensure that an initial care conference has been conducted or scheduled within the required timeframe. Care conferences policy reviewed and remains current. Interdisciplinary team and nurse leadership, educated on care conference policy, which includes timing of when initial conference needs to take place. Social services director or designee will audit 5 random residents per week to ensure initial care conferences are being scheduled/held timely after admission. Results of the audits will be reviewed with the QAPI committee. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 657	Continued From page 25 in bed. R5 indicated he had not had a care conference since admission. R5 indicated there has not been a meeting of any kind to talk about a plan going forward. R5 stated his apartment had been "given up" and spouse was moved out of their joint apartment. R5 stated he isn't sure if the plan is for him to stay where he is at now or go somewhere else as no one has talked to him about the plan. R5 stated he is not doing any therapy. On 1/23/25 at 10:08 a.m., licensed practical nurse coordinator (LPN)-C indicated care conferences are typically completed within about a week or so after admission to the facility. LPN-C stated care conferences are held after therapy and nursing can assess residents. LPN-C stated therapy (physical, occupational and speech), nurse coordinator, social worker, family, and resident are all invited to care conferences. LPN-C stated the social worker sets up care conferences and puts in the notes afterwards. LPN-C verified she did not see a care conference in the EMR but wanted to verify with the social worker if a care conference was completed. LPN-C verified R5 admitted on 12/31/25 (23 days prior). On 1/23/25 at 10:47 a.m., social worker (SW)-A stated the expectation was to have a care conference about a week after admission after therapy and nursing can assess a resident. When asked about R5, SW-A stated, "we have not had one for him as he came in on private pay on hospice his plan is to stay here private pay on hospice." SW-A indicated there was not a plan in place for a care conference for R5. SW-A stated there was no policy that a care conference had to be completed in a certain time frame.	F 657			

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F 657	Continued From page 26 On 1/23/25 at 12:14 p.m., director of nursing (DON) stated care conferences are scheduled typically in the first week or two. DON stated care conferences are done after a resident has been assessed by therapies and nursing. DON stated, "I would have to double check to see if there is requirement for when they have to be completed by." DON did not follow with a requirement.	F 657			
F 684 SS=D	A policy on care conference timing was requested and not received. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure effective collaboration between the facility and a contracted hospice organization that affected 1 of 1 residents (R5) reviewed for hospice services. Findings include: R5's admission Minimum Data Set (MDS) dated 12/31/24, indicated R5 was cognitively intact with no hallucinations or delusions and required maximum assistance for oral hygiene, toileting, dressing lower part of body, footwear, personal	F 684			3/4/25
			Facility collaborated with hospice group and reviewed and updated R5's hospice chart as well as R5's care plan and orders as appropriate. Residents who are on hospice have been audited to ensure that there has been effective collaboration between the facility and a contracted hospice organization. Coordination with Providers policy reviewed and remains current. Nursing staff educated on policy and quality of		

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F 684	Continued From page 27 hygiene, bed mobility, and transfers. R5's diagnosis report, printed 1/23/25, included the following diagnoses: acute kidney failure (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few day), retention of urine (condition where the bladder doesn't empty completely), anemia (body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), Atrial fibrillation (an irregular and often rapid heart rhythm that can lead to stroke and heart failure), congestive heart failure (heart not pumping pump properly), hypertension (high blood pressure), diabetes (condition that affects your blood sugar levels), depression, obstructive sleep apnea (sleep disorder characterized by episodes of a complete or partial collapse of the airway with an associated decrease in oxygen saturation or arousal from sleep), ischemic cardiomyopathy (a condition of weakened heart muscles due to heart attack or coronary heart disease), and chronic kidney disease (a condition in which the kidneys are damaged and can't filter blood as well as they should). R5's hospice chart lacked a calendar of planned hospice visits. Furthermore, the hospice chart lacked a copy of the hospice care plan. There was a section for hospice staff to use for collaboration of care of between the hospice staff and facility staff. This section lacked any coordination from the hospice nursing assistants. R5's care plan, printed 1/23/25, lacked evidence of hospice provider, services provided, contact information, frequency of visits or disciplines visiting R5.	F 684	care regarding collaboration with hospice groups. Education includes information on contents of hospice chart, care plan, and orders for hospice residents. DON or designee to audit all hospice residents' hospice charts and medical records weekly x 4 weeks to ensure effective collaboration between the facility and a contracted hospice organization. Results of the audits will be reviewed with the QAPI committee. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 684	Continued From page 28 R5's Order Summary Report, printed 1/22/25, identified "referral: hospice" on 12/31/24. R5's Order Summary Report lacked evidence of hospice provider name, contact information, services provided, frequency of visits or disciplines visiting R5. R5's Medication Administration Record (MAR/TAR), dated 1/22/25, for January included the following orders: -Hospice Charting. Document any changes in condition in a progress note every day shift on even days for Charting started 1/02/25 -Hospice Charting. Document any changes in condition in a progress note every evening shift on odd days for Charting started 12/31/24 R5's MAR/TAR lacked evidence of hospice provider, contact information, frequency of visits, disciplines visiting or services provided to R5. R5's progress notes, dated 12/31/24 to 1/21/25, were reviewed and identified the following: -1/13/25: RN called hospice regarding R5's urine. -1/8/25: "Foley is patent, maceration in groin hospice informed." -1/3/245: R5 "followed by [identified company] hospice for EOL [end of lift] services." -12/31/24: [R5] being admitted to [identified company] hospice. R5's progress notes lacked evidence of frequency of hospice visits, planned hospice visits, services hospice providing or disciplines providing services to R5 from hospice. R5's Kardex, printed 1/21/25, lacked evidence R5 was receiving hospice services. R5's care sheet, printed 1/21/25, identified R5	F 684			

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F 684	Continued From page 29 shower/bath days were Tuesday and Saturday AM. Care sheet indicates R5 receives hospice services with provider listed. R5's care sheet lacked evidence indicating hospice was responsible for R5's showers. During an interview on 1/21/25 at 8:57 a.m., R5 stated he currently receives hospice services. R5 stated he was not sure when hospice was scheduled to come as they just show up. R5 stated he has gotten music therapy and massage therapy through hospice. R5 verified he has been getting bed baths by hospice and no showers or bathing by facility staff. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and Kardex's to find the information needed to care for residents. NA-A indicated if they had any questions about resident cares/needs, they would ask the nurse. NA-A verified there was important information on the care sheets such as residents name, bath days, how they transfer, if they are continent or incontinent of bowel and bladder and other health information. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 needs staff assist with ADLs and is dependent on staff. NA-C stated, "hospice has been doing his bed baths." NA-C verified they have not been completing R5's showers. On 1/22/25 at 11:31 a.m., NA-D verified they are familiar with R5. NA-D indicated they are not sure when hospice comes to see R5 and stated, "there is a schedule for hospice I think." NA-D stated	F 684			

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F 684	Continued From page 30 they are not sure the services the additional hospice provides for R5, adding there was a hospice book. On 1/22/25 at 11:42 a.m., registered nurse (RN)-C verified they are not sure when R5's hospice nurse comes to the facility. RN-C verified they are familiar with R5. RN-C verified they think it varies when the hospice staff comes to the facility to see R5. RN-C stated she was not sure the last time the hospice nurse seen R5 or the next scheduled visit with R5 was and added, "I can call her with any changes which is what I do." RN-C stated, "the hospice nursing assistant came today and last Wednesday." RN-C reviewed R5's hospice binder and verified the following information: identification of R5's hospice provider, RN care manager, social worker; a section with hospice provider address and phone number; list of standing house orders protocol; and an area for hospice staff to write notes after their visit with R5. RN-C verified the hospice binder, which was used for coordination of care, lacked a calendar of when hospice staff was coming and any notes from nursing assistant. The notes left by the hospice nurse lacked evidence of when the next visit was scheduled for. Furthermore, the hospice binder lacked a copy of the hospice plan of care. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B reviewed and verified R5's care plan lacked information regarding hospice provider. Furthermore, lacked hospice provider name, contact information, services provided, frequency of visits or disciplines visiting R5. On 1/22/25 at 2:56 p.m., NA-B verified they are trained to follow the care sheets, care plans, and			F 684			

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F 684	Continued From page 31 Kardex to help determine resident needs. NA-B stated if they had questions about resident needs, they would ask the nurse. On 1/23/25 at 10:08 a.m., licenses practical nurse coordinator (LPN)-C verified coordination between facility and hospice needs to be occurring. LPN-C verified the care plan needs to be specific to each resident. LPN-C verified R5's care plan lacks hospice information. LPN-C stated the facility should have the hospice care plan which she thinks would be kept in the hospice binder. LPN-C verified R5's hospice binder lacked a calendar or any notification/plan on hospice visits, did not have any notes entered by nursing assistants on what care was provided during visits or a hospice care plan. LPN-C verified the binder should include this information. On 1/23/25 at 12:18 p.m., director of nursing (DON) stated it is expected that the facility and hospice are coordinating care. DON verified resident's hospice information is kept in the hospice binder and should include hospice care, communication of scheduled visits, POLST and a log for hospice staff to write in after visits. DON verified the facility, and hospice should be sharing the responsibility of showering residents. DON reviewed R5's shower log and verified "based on the documentation, I would be unable to determine if R5 is getting a shower and would have to follow up with the nursing assistants." DON stated coordinating care was important to ensure "we are providing the best care." A facility policy on coordination with providers was requested and not received.			F 684			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI			F 690			3/4/25

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F 690	Continued From page 32 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 690			
			R4 has discharged from TCU. Staff are		

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F 690	Continued From page 33 review the facility failed to comprehensively reassess and demonstrate adequate justification for the continued use of an indwelling catheter for 1 of 2 residents (R4) reviewed who used a catheter. Further, the facility failed to develop a comprehensive plan of care to monitor and assess residents with indwelling catheters for 1 of 2 residents (R4) reviewed who used a catheter. The facility further failed to ensure a resident who was continent of bowel received services to maintain bowel continence for 1 of 2 residents (R5) reviewed for bowel and bladder. Findings include: R4's admission Minimum Data Set (MDS), dated 1/9/24, indicated R4 was admitted to the care facility on 12/4/24, had severe cognitive impairment and was dependent on staff for bathing, toileting, and dressing. The MDS further indicated R4 had a Foley catheter on place. R4's Urology Consult Note, dated 12/27/24, indicated R4 had an indwelling Foley catheter placed by urology that day as R4 relied on daily intermittent catheterization (a process where the catheter is removed after each use vs an indwelling catheter which remains in place) managed by R4's wife who had difficulty performing catheterization while R4 was in the hospital. The Urology note indicated to "maintain Foley catheter at discharge, until patient is back to baseline or in 7-14 days. We can help arrange follow up to remove this otherwise okay for wife to deflate balloon and resume cathing 2-3 times daily after discharge." R4's Hospital Discharge note, dated 1/3/25, indicated "unable to straight cath on 12/27/24.			F 690	toileting R5 per care plan and resident preference to maintain bowel continence. All residents with indwelling catheters audited to ensure the use of the indwelling catheter is appropriate based on resident's medical condition, functional status, and the risk of complications related to catheter use. All residents with indwelling catheters audited to ensure care plan in place. All residents who are continent of bowels and require staff assistance with toileting have been audited to ensure that residents are assisted with toileting according to care plan and/or resident preference to maintain bowel continence. Incontinence and Skilled Catheter Use policies reviewed and remain current. Licensed nurses educated on medical need for indwelling catheters, working with providers and specialists to ensure that indwelling catheters are being used and care planned appropriately. Nursing staff re-educated on providing assistance with toileting to residents who require assistance with toileting to maintain residents' continence. DON or designee to audit all residents with indwelling catheters weekly x 4 weeks to ensure appropriate use of indwelling catheters. DON or designee to audit 5 random residents who are continent of bowels and require staff assistance with toileting to ensure residents are being assisted with toileting according to care plan and/or resident		

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F 690	Continued From page 34 Urology placed a Foley 12/27/24. Plan to discontinue Foley and resume intermittent straight cath with wife to manage at TCU [transitional care unit] per discussion with wife and TCU facility. R4's Physician Progress note, dated 1/6/25, indicated R4 had a comorbidity of urine retention due to Parkinson's Disease. The note further indicated "early discontinuation of Foley if present to help prevent CAUTI [catheter associated urinary tract infection] and initiation of intermittent straight catheterizations recommended. Initiate timed voids and bladder training as indicated." R4's Physician Progress note, dated 1/20/25, indicated the same catheter recommendations from the note dated 1/6/25. R4's Physician Orders, dated 1/20/25, indicated an order for Ciprofloxacin (an antibiotic) 500 mg twice a day for 7 days for a urinary tract infection. During an interview on 1/22/25 at 11:00, the nurse coordinator (NC) stated she believed that R4's spouse had wanted the catheter to stay in place as she had been "running the show." The NC was unsure what the ongoing plan was for R4's catheter. During an interview on 1/22/25 at 12:44 p.m., R4's nurse practitioner (NP) stated that R4's Foley catheter was placed due to R4's spouse having a hard time with the intermittent straight catheterization for R4 and had requested a Foley catheter. During an interview on 1/23/25 at 11:35 a.m., the director of nursing (DON) and NC stated if there	F 690	preference to maintain bowel continence per week x 4 weeks. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 690	Continued From page 35 were no specific orders for a Foley catheter, the facility had standing orders to remove the Foley catheter and attempt a void trial (a procedure that assess a person's ability to urinate normally without a catheter.) During an interview on 1/23/25 at 1:09 p.m., R4's physician stated R4's spouse had been managing R4's intermittent straight catheterizations but that the care facility staff would be able to manage the catheterizations if necessary. The physician stated R4 would be moving to the assisted living next week and would "probably end up needing a long term cath[eter] with monthly changes." A facility policy titled Catheter, revised 1/2025, indicated "Vivie will ensure that a resident who admits to a Skilled Nursing Facility (SNF) without an indwelling catheter will not be catheterized unless the resident's clinical condition demonstrates that catheterization is necessary; or that a resident who enters the facility with an indwelling urinary catheter or subsequently receives one, is assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization is necessary. " R5 R5's admission Minimum Data Set (MDS), dated 1/6/25, identified R5 was cognitively intact and required substantial/maximal staff assistance with toileting care. Further, the MDS outlined R5 as being always incontinent of bowel, however, a toileting program to manage the resident's bowel			F 690			

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F 690	Continued From page 36 continence was marked no with a check mark. During interview on 1/21/25 at 8:57 a.m., R5 was observed lying in bed. R5 stated he would like to use the toilet instead of going in his incontinent pad for bowel movements. R5 stated he has a Foley catheter (a flexible tube that drains urine from the bladder into a bag). R5 stated staff does not offer to bring him to the bathroom and added, "they tell me they will just clean me up." R5 stated, "it is so unnatural to just go and get cleaned up." R5 stated his preference is to use the bathroom/toilet. R5's care plan, printed 1/23/25, identified the following: - "TOILET USE: The resident is totally dependent on staff for toilet use." - "TRANSFER: The resident is totally dependent on staff for transferring." - "The resident is WEIGHT-BEARING." - "Encourage the resident to sit on the toilet to evacuate bowels if possible." - "Ensure the resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible." R5's progress notes, dated 12/31/24 to 1/23/25, were reviewed and lacked evidence of a toileting program attempted. Furthermore, the progress notes lacked evidence of offering R5 the use of a toilet or a bed pan [a device used as a receptacle for the urine and/or feces of a person who is confined to a bed]. R5's Order Summary Report, printed 1/22/25, lacked evidence of toileting program.			F 690			

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F 690	Continued From page 37 R5's Kardex, printed 1/21/25, indicated the following: - "Bladder/Bowel: Encourage resident to sit on toilet to evacuate bowels if possible." - "Toileting: Ensure the resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible." - "Mobility: The resident is WEIGHT-BEARING." - "Transferring: TRANSFER: The resident is totally dependent on staff for transferring." - "Toileting: TOILET USE: The resident is totally dependent on staff for toilet use." R5's care sheet, printed 1/21/25, indicated R5 continent of bowel and bladder. Furthermore, indicated on EBP [enhanced barrier precautions] for Foley. R5's Nursing Assessment - Admission/Readmission, dated 12/31/24, indicated the following: R5 was occasionally incontinent of bowel. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and Kardex's to find the information needed to care for residents. NA-A indicated if they had any questions about resident cares/needs, they would ask the nurse. NA-A verified there was important information on the care sheets such as residents name, bath days, how they transfer, if they are continent or incontinent of bowel and bladder and other health information. On 1/21/25 at 2:58 p.m., NA-C verified they are			F 690			

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F 690	Continued From page 38 familiar with R5. NA-C verified that R5 needs staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week, adding "we go in and reposition him." NA-C stated R5's incontinent pad is check and changed when R5 is repositioned, verifying R5 has not been offered a bed pan or use of the bathroom or toilet. On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D verified R5 does not use the toilet or bed pan. NA-D verified they have not offered R5 a bed pan or toilet as R5 was to be repositioned and changed. NA-D indicated they have not transferred R5 "for a while" and were unable to give a time frame of the last time they assisted him transferring out of bed. During a follow up interview on 1/22/25 at 2:50 p.m., R5 stated again staff had not offered to bring him to the bathroom which is what he prefers. R5 stated he has not been in the bathroom in his room. R5 stated he knows when he must have a bowel movement and when he tells staff they tell him they will clean him up after he goes. R5 stated he has not been offered any other options beside "getting cleaned up" after having a bowel movement. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated this would be added to the care plan. RN-B stated a resident would be offered the bathroom but if they couldn't use the bathroom, it would be expected the resident was offered a bed pan. RN-B verified R5's care plan did not have a preference to not use the bathroom, bedside commode or bed pan.	F 690			

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F 690	Continued From page 39 On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care sheets, care plans, and Kardex to help determine resident needs. NA-B stated if they had questions about resident needs, they would ask the nurse. NA-B stated residents' preferences would be on their care plan. On 1/23/25 at 10:28 a.m., licenses practical nurse coordinator (LPN)-C verified R5's admission nursing assessment indicates R5 was continent of bowels with occasional incontinence. Furthermore, LPN-C verified R5's care plan indicates R5 was able to bear weight and dependent on staff for toileting needs. LPN-C stated the expectation would be staff would be assisting with toileting as R5's not independent. On 1/23/25 at 12:15 p.m., director of nursing (DON) verified resident preferences and needs should be on resident's care plan. DON stated it is important "so we can provide the best care." On 1/23/25 at 1:21 p.m., RN-F verified they are familiar with R5. RN-F verified R5 has not been transferred out of bed in at least the last couple of weeks to use the bathroom. RN-F stated they were unsure if they were transferred out of bed prior to that. A facility policy titled Incontinence, revised 1/2025, indicated the following: "When deemed appropriate, Vivie staff will implement interventions that may promote achieving the highest practicable level of functioning, may prevent the development of incontinence, or minimize a decline or lack of improvement in degree of continence include providing treatment and services to address	F 690			

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F 690	Continued From page 40 factors that are potentially modifiable, such as: a. Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, neurological impairments, etc. b. Removing or improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode or reducing the distance to the toilet); c. Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion); d. Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration); and e. Implementing a fluid and/or bowel management program to meet the assessed needs. f. Bladder Rehabilitation/Bladder retraining g. Pelvic floor muscle rehabilitation h. Prompted voiding i. Habit training/scheduled voiding"	F 690			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758			3/4/25

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NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II				STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118			
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F 758	Continued From page 41 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the			F 758	R283 had order added on 01/23/25 for		

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F 758	Continued From page 42 facility failed to ensure a resident that was prescribed psychotropic medications was monitored for side effects, for 1 of 2 residents (R283) reviewed for unnecessary medications. Findings include: R283's admission Minimum Assessment Data (MDS) dated 1/12/25, indicated R283 had moderate cognitive impairment and no mood or behavior concerns. R283's MDS indicated diagnoses of pneumonia, heart failure, and malnutrition. R283's clinical diagnosis report indicated the following diagnoses: acute respiratory failure, severe protein calorie malnutrition, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (lung disease that blocks the airflow and makes it difficult to breathe), abscess of lung with pneumonia and acute systolic congestive heart failure. R283's clinical orders report included the following orders: " 1/6/25- trazadone (antidepressant also used to treat insomnia) HCL oral tablet 50 milligrams (mg), give 0.25 tablet orally at bedtime for insomnia. " 1/7/25- buspirone HCL oral tablet 5 mg, give 0.5 tablet orally once a day for repeated episodes of anxiety. R283's January Medication Administration Record (MAR) printed on 1/23/25, indicated an order dated 1/8/23 started on the evening shift to monitor psychotropic side effects to medications every shift until the night shift of 1/14/25.	F 758	monitoring side effects related to psychotropic medications. All residents who are prescribed psychotropic medications have been audited to ensure they have orders in place to monitor for side effects related to psychotropic medications. Medication Management policy reviewed and remains current. Licensed nurses and HUCs educated on necessity for side effect monitoring orders to be in place for all residents who are prescribed psychotropic medications and how to create those orders. DON or designee to audit 5 random residents per week x 4 weeks who are prescribed psychotropic medications to ensure that side effect monitoring orders are in place. Frequency of the audits will be increased, decreased, or discontinued as determined by the QAPI committee.		

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F 758	Continued From page 43 During interview on 1/23/25 at 9:18 a.m., licensed practical nurse (LPN)-A stated she monitored for side effects every time she administered psychotropic medications. LPN-A added to her knowledge "we are supposed to monitor our residents as long as they take a psychotropic medication." During interview on 01/23/25 at 11:12 a.m., care coordinator licensed practical nurse (LPN)-C indicated side effects to psychotropic medications were monitored for as long as a resident received one of those medications. The residents were monitored continuously, every shift without an end date. During interview on 01/23/25 at 12:56 p.m., director of nursing (DON) stated the documentation of side effects was done every shift for psychotropic medications, and a progress note is created if side effects are identified.	F 758			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880			3/4/25

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F 880	Continued From page 44 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and			F 880			

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F 880	Continued From page 45 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper personal protective equipment (PPE) use for 1 of 3 residents (R4) on enhanced barrier precautions (EBP) reviewed for proper PPE use during survey. In addition, the facility failed to ensure a comprehensive Infection Prevention and Control Program (IPCP) was maintained to include an ongoing analysis of collected data to help identify and reduce the risk of infection spread and outbreak. This had potential to affect all 30 residents, staff, and visitors. Findings include: R4's admission Minimum Data Set (MDS), dated 1/9/25, indicated R4 was dependent on facility staff for bathing, toileting and dressing and had a Foley catheter in place. During observation on 1/22/25 at 9:05 a.m., nursing assistant (NA)-E and NA-F entered R4's			F 880	R4 was reviewed and signage and PPE were in place for enhanced barrier precautions, and enhanced barrier precautions were care planned. NA-E and NA-F were re-educated on proper use of PPE. R4 has had no ill effects from incident. Facility signed a contract with an interim nurse to serve as the acting Infection Preventionist (IP) onsite to ensure a comprehensive infection control program is maintained. Full house audit completed to identify all residents that require enhanced barrier precautions to ensure they have signage and PPE in place and that this is care planned. Education completed with all staff regarding enhanced barrier precautions, including how and when to use PPE. Infection Preventionist is ensuring a		

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F 880	Continued From page 46 room. A sign was posted on R4's door indicating R4 was on enhanced barrier precautions (EBP) indicating staff must wear gown and gloves when providing "high contact resident care activities" including bathing, dressing, transferring and brief changes. NA-E and NA-F did not don appropriate PPE when they failed to wear a gown while providing high contact activities. NA-E and NA-F donned gloves and provided R4 with a partial bed bath, brief change and peri care, transferred him to his recliner chair via a mechanical lift. R4 was observed to have a Foley catheter in place with a drainage bag hanging on the side of the bed. NA-F emptied the urine in R4's drainage bag into a graduated cylinder. During all cares, neither NA-E nor NA-F were observed to wear a gown. During an interview on 1/22/25 at 1:43 p.m., R4's family member (FM)-A stated she did not see staff wearing gowns "very often", stating therapy staff were often wearing gowns but otherwise she did not see staff wear gowns. During an interview on 1/22/25 at 1:47 p.m., NA-F stated R4 was on EBP because he had a Foley catheter and that she was aware she should have had a gown on when providing cares but "forgot". During an interview on 1/22/25 at 11:00 a.m., the nurse coordinator (NC) and director of nursing (DON) stated that all staff should be wearing gloves and gowns when providing care in residents' rooms on EBP, stating it was important to prevent the spread of infection.	F 880	comprehensive infection control program is maintained, to include ongoing surveillance and analysis of collected data to help identify and reduce the risk of infection. Infection preventionist or designee will observe high contact cares for 5 residents requiring enhance barrier precautions per week x 4 weeks to ensure PPE is utilized appropriately. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. Ongoing surveillance and analysis of collected data to help identify and reduce the risk of infection will be reported to QAPI committee on a continuing basis.		

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F 880	Continued From page 47 SURVEILLANCE The facility' infection control program, including surveillance and analysis data, was requested. The following was provided: a white three ring binder titled "Infection Prevention Resource Manual." The binder lacked any specific data related to the facility. Furthermore, the binder lacked any surveillance data or analysis data of the facility. During an interview on 1/22/25 at 1:46 p.m., director of nursing (DON) stated she was currently the acting facility infection preventionist and was responsible for overseeing the infection control program. DON verified there was no current surveillance of infections, resident symptoms or tracking of antibiotic use. DON stated she was unable to provide any current type of surveillance or data analysis. DON stated there are currently no audits being completed of staff adherence/proper use of PPE or handwashing. DON stated the facility was currently not tracking resident antibiotic use to ensure proper use and follow up, tracking of prophylactic antibiotics to ensure proper use and follow up and she was unaware if any antibiotic time-outs were occurring. During a follow up interview on 1/23/25 at 8:49 a.m., DON verified there are currently no antibiotic time-outs occurring at the facility. A facility policy titled Infection Control Surveillance, revised 1/2025, indicated "The Infection Preventionist (IP) or Director of Nursing (DON) will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that			F 880			

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F 880	Continued From page 48			F 880			
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an antibiotic stewardship program which included development of protocols and a system to monitor appropriateness of antibiotic use to prevent antibiotic resistance and help prevent the spread of infectious diseases. This had the potential to affect all 30 residents residing in the facility. Findings include: During an interview on 1/22/25 at 1:46 p.m., director of nursing (DON) stated she was currently the acting facility infection preventionist and was responsible for overseeing the infection control program. DON verified the facility was currently not tracking resident antibiotic use to ensure proper use and follow up. DON verified there are currently no tracking of prophylactic			F 881	Facility signed a contract with an interim nurse to serve as the acting Infection Preventionist (IP) onsite to ensure a comprehensive infection control program is maintained. All residents have the potential to be affected by this practice. No ill effects occurred to the residents at the facility. The facility has appointed the Infection Preventionist to be the antibiotic stewardship program coordinator who will lead the development and implementation of the antibiotic stewardship program. Antibiotic stewardship policy reviewed and remains current. Education initiated with nursing staff regarding antibiotic stewardship protocols and the importance of appropriate antibiotic use in preventing		3/4/25

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F 881	Continued From page 49 antibiotics to ensure proper use and follow up. DON stated she was unaware if any antibiotic time-outs were occurring. During a follow up interview on 1/23/25 at 8:49 a.m., DON verified there are currently no antibiotic time-outs occurring at the facility. A facility policy titled Antibiotic Stewardship, revised 1/2025, indicated the Antibiotic Stewardship program included the following: - "A designated Registered Nurse (RN) as the Infection Preventionist (IP) responsible for assessing, developing, implementing, monitoring, and managing the IPCP, and is - The IP will be certified in Infection Prevention and Control." - "A system to monitor antibiotic use (i.e., antibiotic use reports, antibiotic resistance reports, response to antibiotics and lab results when available to determine if the antibiotic is still indicated or requires adjustments)." Furthermore, the policy identified: "resident antibiotic regimens will be documented on an antibiotic surveillance tracking form. The information gathered will include: 1) Resident name and medical record number; 2) Unit and room number; 3) Date symptoms appeared; 4) Name of antibiotic; 5) Start date of antibiotic; 6) Pathogen identified; 7) Site of infection; 8) Date of culture; 9) Stop date; and 10) Total days of therapy."	F 881	resistance and infection spread. Infection Preventionist will audit all residents who have prescriptions for antibiotics weekly x 4 weeks to ensure antibiotic use is appropriate and being tracked. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. Antibiotic use will continue to be reported at QAPI meetings on a continuing basis.		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)	F 882			3/4/25

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F 882	Continued From page 50 §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the acting infection preventionist had completed specialized training in infection prevention and control. This had the potential to affect all 30 residents residing in the facility. Findings include: On 1/22/25 at 1:26 p.m., director of nursing (DON) stated she was currently the acting facility infection preventionist and was responsible for overseeing the infection control program. DON verified that she had not completed specialized training for infection prevention and control. DON verified they were not currently enrolled in any specialized training at this time nor had any specialized infection control education scheduled.			F 882	Facility signed a contract with an interim nurse to serve as the acting Infection Preventionist (IP). This nurse has completed specialized training in infection prevention and control. All residents have the potential to be affected by this practice. No ill effects occurred to the residents at the facility. Infection control policy reviewed and remains current. Education initiated with all staff on the requirement to have an infection preventionist on staff and were given the contact information of the Infection Preventionist. Facility will continue to keep Infection		

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F 882	Continued From page 51 DON verified no other staff in the facility had specialized training in infection prevention and control. A facility policy titled Infection Preventionist, revised 1/2025, indicated the following: "The IP will be a Registered Nurse or have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; will be qualified by education, training, experience or certification; Work at least part-time at the facility; and have completed specialized training in infection prevention and control. Continuing Education: The designated IP will maintain current knowledge in infectious disease and epidemiology by: o Attending programs and courses provided by infection control organizations o Accessing to published guidelines for best practice for infection prevention o Accessing current federal, state, local regulations related to infection control requirements."	F 882	Preventionist employed at least 20 hours per week. Infection Preventionist will instruct Designee on monitoring and other duties as needed. Facility will ensure that when hiring an Infection Preventionist, that the individual meets requirements for specialized training in infection prevention and control.		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 883			3/4/25

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F 883	Continued From page 52 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 883			

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F 883	Continued From page 53 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of the 6 residents (R5, R9, R26, R28, and R133) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). In addition, the facility failed to ensure 1 of the 5 residents (R26) was offered and/or provided the influenza vaccination as recommended by the CDC. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated October 2024, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer, after 5 years, the Pneumococcal 20-valent Conjugate Vaccine (PCV20) or Pneumococcal 21-valent Conjugate Vaccine (PCV21) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. This also identified an adult over 50 years old, who received one dose of PPSV23 at any age should be offered either option A (PCV20 or PCV21) or option B (PCV15) after one year. According to 2024-2025 CDC Flu Vaccination			F 883	Residents R5, R9, R26, R28, R133 have discharged from the facility. All eligible residents are being offered influenza and pneumococcal vaccines. All residents have the potential to be affected. Whole house audit completed to ensure that all residents have been offered the opportunity to receive the influenza and pneumococcal vaccination as recommended by the CDC. Pneumococcal Vaccines and Influenza Vaccines policies reviewed and remain current. Licensed nurses educated regarding Influenza and Pneumococcal Immunizations and facility process. New vaccination consent/declination forms created to provide ease in getting signatures and orders from providers. Infection Preventionist Nurse or designee will audit all new admissions weekly x 4 weeks for Influenza and Pneumococcal vaccination status. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		

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

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F 883	Continued From page 54 Recommendations Adopted article, dated 8/29/2024, the Advisory Committee on Immunization Practices (ACIP) recommended an annual influenza (flu) vaccine for everyone 6 months or older in the United States. R5's face sheet, printed 1/23/25, indicated R5 was 87 years old. The immunization record, dated 1/23/25, indicated R5 received a PPSV23 and PCV13 on 10/18/02 followed by the PPSV on 6/22/11. R5's electronic medical record (EMR) and paper chart lacked evidence of shared clinical decision making occurring with the physician for PCV20 or PCV21 as it was more than 5 years after the previous pneumococcal dose. The records lacked evidence that R5 was offered or received PCV20 or PCV21 or education was provided. R9's face sheet, printed 1/23/25, indicated R9 was 87 years old. The immunization record, dated 1/23/25, indicated R9 received PPSV23 on 3/24/03. R9's EMR and paper chart lacked evidence of shared clinical decision making occurring with the physician for PCV20 or PCV21 as it was more than 5 years after the previous pneumococcal dose. The records lacked evidence that R9 was offered or received PCV20, PCV21, or PCV15 or education was provided. R26's face sheet, printed 1/23/25, indicated R26 was 73 years old. The immunization record, dated 1/23/25, indicated R26 did not have any pneumococcal immunizations on file. Furthermore, R26's immunization lacked evidence for influenza immunization. R26's EMR and paper chart lacked evidence of R26 being offered or received any pneumococcal doses or education. Furthermore, the records lacked	F 883			

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F 883	Continued From page 55 evidence of R26 being provided education, offered, or receiving an annual influenza immunization. R28's face sheet, printed 1/23/25, indicated R28 was 79 years old. The immunization record, dated 1/23/25, indicated R28 received PPSV23 on 9/23/2008 followed by a PPSV23 on 9/2/14 followed by a PCV13 on 9/4/15. R28's EMR and paper chart lacked evidence of shared clinical decision making occurring with the physician for PCV20 or PCV21 as it was more than 5 years after the previous pneumococcal dose. The records lacked evidence that R28 was offered or received PCV20 or PCV21 education was provided. R133's face sheet, printed 1/23/25, indicated R133 was 87 years old. The immunization record, dated 1/23/25, indicated R133 received PPSV23 on 1/1/2008 followed by a PCV13 on 7/26/16 followed by a PPSV23 on 9/24/19. R133's EMR and paper chart lacked evidence of shared clinical decision making occurring with the physician for PCV20 or PCV21 as it was more than 5 years after the previous pneumococcal dose. The records lacked evidence that R133 was offered or received PCV20 or PCV21 education was provided. On 1/22/25 at 10:13 a.m., licensed practical nurse (LPN)-A stated nursing offers immunizations upon admission. LPN-A stated if a resident declines an immunization, it would be documented in a progress note and if a resident accepts a immunization than we would work on getting a physician order and then it would show up on the medication administration record (MAR).	F 883			

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F 883	Continued From page 56 On 1/22/25 at 1:46 p.m., director of nursing (DON) verified she was the acting infection preventionist (IP). DON indicated during the admission process; a Minnesota Immunization Information Connection (MIIC) report is pulled which will show which immunizations a resident previously had. DON verified pneumococcal, COVID and influenza immunizations are offered as part of the admission process. DON stated the documentation of residents being offered/educated about immunizations would be found in either progress notes or the residents' hard chart. During a follow up interview on 1/23/25 at 2:04 p.m., DON verified the following: -R5's EMR and hard chart lacked evidence of R5 being offered, receiving, or provided education on PCV20 or PCV21 until after survey entrance and would be eligible for an updated pneumococcal dose. -R9's EMR and hard chart lacked evidence of R9 being offered, receiving, or provided education on PCV20, PCV21 or PCV15 until after survey entrance and would be eligible for an updated pneumococcal dose. -R26's EMR and hard chart lacked evidence of R26 being offered, receiving, or provided education on PCV20 or PCV21 until after survey entrance and would be eligible for an updated pneumococcal dose. DON verified R26 would be eligible for an influenza vaccine. DON verified EMR and hart chart lacked evidence of R26 being offered, receiving, or being provided an influenza vaccine. -R28's EMR and hard chart lacked evidence of R28 being offered, receiving, or provided education on PCV20 or PCV21 until after survey			F 883			

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F 883	Continued From page 57 entrance and would be eligible for an updated pneumococcal dose. -R133's EMR and hard chart lacked evidence of R133 being offered, receiving, or provided education on PCV20 or PCV21 until after survey entrance and would be eligible for an updated pneumococcal dose. DON verified using the current CDC October 2024 pneumococcal recommendations. A facility policy titled Pneumococcal Vaccines, revised 1/2025, indicates that "all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections." A facility policy titled Influenza Prevention and Outbreak Management, revised 1/2025, indicated the facility will "offer vaccination to residents upon admission."	F 883			

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/21/25-1/23/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

02/13/25

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2 000	Continued From page 1 identify the date when they will be completed. In addition to the recertification survey, the following complaint was reviewed with no deficiency issued. - H56183582C (MN00109394) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000			

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2 000	Continued From page 2	2 000			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for 1 of 5 residents (R5) reviewed. Findings include: R5's admission Minimum Data Set (MDS) dated 1/6/26, indicated R5 admitted to facility on 12/31/24, had intact cognition with no hallucinations or delusion. In Section H-Bladder and Bowel, in section H0100 Appliances under section A: Indwelling catheter (including suprapubic catheter and nephrostomy tube) it was not marked with a check mark. Under section Z: none of the above: it is marked with a	2 550	Corrected	2/21/25	

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2 550	Continued From page 3 check mark. During interview and observation on 1/21/25 at 8:57 a.m., R5 was observing laying on his bed. R5 was observed to have a catheter bag hanging from his bed. R5 stated they have had a catheter for "way too long." R5 stated they had a catheter prior to coming to the facility. On 1/21/25 at 2:58 p.m., nursing assistant (NA)-C verified that R5 had a catheter since arriving at the facility. On 1/23/25 at 10:25 a.m., licensed practical nurse coordinator (LPN)-C verified R5 was admitted to the facility with an indwelling urinary catheter. On 1/23/25 at 11:03 a.m., registered nurse (RN)-A verified they complete MDS's for the facility. RN-A verified R5's admission MDS on 1/6/25 was coded as R5 did not have a catheter upon admission. After review of chart, RN-A verified the MDS was coded incorrectly and verified R5 did have a catheter at the time the assessment was completed. RN-A stated accuracy of MDS is important for patient care. RN-A stated they were going to correct the MDS and resubmit it correctly. A facility policy titles Minimum Data Set Policy, revised 1/2025, indicates the facility "will submit an Admission assessment for all residents who are admitted to the nursing facility regardless of their length of stay or payer source." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related	2 550			

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2 550	Continued From page 4 to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate care was provided for 1 of 5 residents (R29) reviewed for comprehensive care plan. Findings include: R5's admission Minimum Data Set (MDS), dated 1/6/25, indicated R5 was admitted on 12/31/24, had intact cognition and required maximum assistance for oral hygiene, toileting, dressing lower part of body, footwear, personal hygiene,	2 565	Corrected	2/21/25	

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2 565	Continued From page 5 bed mobility, and transfers. R5 required touching assistance for upper body dressing. Noted for tub/shower transfer, not applicable. R5's MDS indicated no behaviors were present, and no rejection of care exhibited. Section H: Bladder and Bowel indicating R5's always continent of bowel. Section V: Care Area Assessment (CAA) summary, the following care areas were triggered and marked as addressed in care plan: communication; ADL function/rehabilitation potential; urinary incontinence and indwelling catheter; falls; nutritional status; dental care; pressure ulcer and psychotropic drug use. R5's diagnosis report, printed 1/23/25, included the following diagnoses: acute kidney failure (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few day), retention of urine (condition where the bladder doesn't empty completely), diabetes (condition that affects your blood sugar levels), anemia (body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), Atrial fibrillation (an irregular and often rapid heart rhythm that can lead to stroke and heart failure), congestive heart failure (heart not pumping pump properly), hypertension (high blood pressure), depression, obstructive sleep apnea (sleep disorder characterized by episodes of a complete or partial collapse of the airway with an associated decrease in oxygen saturation or arousal from sleep), ischemic cardiomyopathy (a condition of weakened heart muscles due to heart attack or coronary heart disease), and chronic kidney disease (a condition in which the kidneys are damaged and can't filter blood as well as they should). R5's Order Summary Report, dated 1/22/25,	2 565			

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2 565	Continued From page 6 indicated the following orders: - hospice referral on 12/31/24. -Apixaban (used to prevent stroke and blood clots) 5 milligrams (mg) tablet; give 2.5 mg by mouth two times a day for CVA [cerebral vascular accident], stroke started 12/31/24 -Gabapentin (anti-convulsant medication which can be used to treat nerve pain) 300 mg capsule; give 1 capsule by mouth one time a day for neuropathic pain [order entered twice for two different times during the day] started 12/31/24 -Gabapentin 300 mg capsule; give 2 capsules by mouth at bedtime for neuropathic pain started 12/31/24 -haloperidol (antipsychotic medication) tablet 1 mg; give 1 tablet by mouth every 4 hours as needed for nausea/vomiting -Hydromorphone (opioid pain medication) HCL 2 mg tablet; give 1 mg by mouth every 4 hours as needed for pain, dyspnea (shortness of breath) started 12/31/24 -mirtazapine 15 mg tablet; give 0.5 tablet by mouth at bedtime for MDD (major depressive disorder) started 12/31/24 R5's care plan, printed 1/23/25, identified the following: -"Resident has potential/actual risk of abuse from (self/others) to admission" with no goal or interventions listed. -"The resident has an ADL self-care performance deficit" with no goal listed the following interventions: -"Mobility/Safety/Medical Devices: (Examples: TLSE, Splint, Brace, Walker, Wheelchair, Oxygen, Wound Vac, etc). " -"Bed Mobility: The resident is totally dependent on staff for repositioning and turning in bed (SPECIFY FREQ) and as necessary." -"The resident has constipation r/t [related to]"	2 565			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 565	Continued From page 7 with a goal and interventions. - "The resident is on anticoagulant therapy r/t" with a goal and interventions. - "The resident is on pain medication therapy r/t" with a goal and interventions. - "The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for pressure ulcer development r/t" with a no goal listed with three interventions. - "The resident has potential/actual impairment to skin integrity of (SPECIFY location) r/t" with no goal listed with three interventions. R5's care plan lacked evidence of the following areas being identified in the care plan after identified being in the CAA: communication, urinary incontinence and indwelling catheter, falls, psychotropic drug use. R5's care plan lacked evidence of R5's cognitive abilities, behavioral symptoms, resident specifics regarding mobility/safety/medical devices (what medical devices R5 utilizes), resident specific how frequent resident should be repositioned and turned in bed, resident specific pressure ulcer concerns, resident specific skin integrity concerns, specifics relating to pain/anticoagulant/constipation. Furthermore, the care plan lacked any coordination with hospice or discharge plan. Additionally, R5's care plan lacked a goal for focus areas for: - "Resident has potential/actual risk of abuse from (self/others) to admission" - "The resident has an ADL self-care performance deficit" - "The resident has limited physical mobility" - "The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for pressure	2 565			

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2 565	Continued From page 8 ulcer development r/t" -"The resident has potential/actual impairment to skin integrity of (SPECIFY location) r/t" In addition, R5's care plan lacked any interventions for the focus area of -"Resident has potential/actual risk of abuse from (self/others) to admission" Additionally, R5's care plan lacked evidence of R5's preference of a shower versus a bed. R 5' s' care plan lacked evidence of R5's specific needs to transfer (assist of 2 staff, or Hoyer lift). Additionally, R5's care plan lacked evidence of R5's preference to use the bathroom vs incontinent pad and need for Foley catheter. R5's care plan lacked evidence of R5's preferences for therapeutic activities. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and Kardex's to find the information needed to care for residents. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 needs staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week, adding "we go in and reposition him." NA-C stated R5's incontinent pad is check and changed when R5's repositioned, verifying R5 has not been offered a bed pan, use of the bathroom or toilet. NA-C was unable to indicate whether a bed bath was NA-C preference versus a shower. NA-C verified R5 had a catheter upon admission to the facility. On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D verified they do not offer	2 565			

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2 565	Continued From page 9 R5 a bed pan, or toilet as R5 was to be repositioned and changed. NA-D indicated they have not transferred R5 "for a while" and were unable to give a time frame of the last time they assisted. NA-D indicated they "think he is a Hoyer". NA-D indicated they are not unsure when hospice comes to see R5 and stated, "there is a schedule for hospice I think." NA-D verified nursing assistants use Kardex and care sheets to know resident needs. During a follow up interview on 1/22/25 at 2:50 p.m., R5 stated he prefers a shower vs a bed bath. Furthermore, R5 stated he prefers to use bathroom vs an incontinent pad. R5 verified he has a Foley catheter. R5 stated his spouse (who resides in a separate part of facility) visits daily, enjoys listening to music and likes to watch TV. R5 stated he enjoys watching football. R5 stated he doesn't know if he is going to discharge from facility but would like to stay with his spouse but doesn't know if that is possible. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated preferences would be added to the care plan. RN-B stated that if a resident has a preference to have a bed bath vs a shower, that would have been assessed and added to the care plan for continuity of care. RN-B verified R5's current plan as of 1/22/25 and lacked items listed above. On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care plans, care sheets, and Kardex's to help determine resident needs. NA-B stated residents' preferences would be on their care plan such as if a resident preferred a bed bath vs a shower.	2 565			

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2 565	Continued From page 10 On 1/23/25 at 10:08 a.m., licenses practical nurse (LPN)-C nurse coordinator indicated a comprehensive care plan should include all activities of daily (ADL) needs (transferring, dressing, ambulating, etc.), any wounds or potential skin issues, antibiotics and dependent on the resident. LPN-C indicated the entire team, including social services adds to the care plan. LPN-C verified hospice information included hospice contact information, hospice goals should be on the comprehensive care plan. LPN-C verified resident preferences should be on the comprehensive care plan such as if a resident prefers a bed bath vs a shower or if a resident prefers to stay in bed vs getting out of bed. LPN-C verified the comprehensive care plan needs to be specific to each resident and all areas need to be completed to be resident specific. LPN-C verified R5's care plan lacks hospice information, preferences with shower vs bed bath, responsibility of R5's showers. LPN-C verified R5's care plan was not comprehensive or resident specific. On 1/23/25 at 12:15 p.m., director of nursing (DON) stated a comprehensive care plan needs to be completed by day 21 after admission. DON verified the comprehensive care plan needs to be resident specific and would include treatments, preferences, hospice information, diagnosis and other pertinent information. DON stated the comprehensive care plan needs to be resident focused. A facility policy titled Care plans, dated 1/2025, indicated "the comprehensive care plan must describe the following: services that are to be furnished to attain or maintain the resident's	2 565			

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2 565	Continued From page 11 highest practicable physical, mental and psychosocial well-being ..." Furthermore, "the comprehensive care plan must reflect interventions, the specific care and services that will be implemented, to enable each resident to meet his/her objectives." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is developed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565			
2 680	MN Rule 4658.0465 Subp. 1 Transfer, Discharge, and Death: Dis. Summay Subpart 1. Discharge summary at death. When a resident dies, the nursing home must compile a discharge summary that includes the date, time, and cause of death. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure adequate and/or required information was documented to ensure continuity of care when transferred emergently to a hospital	2 680	Corrected	2/21/25	

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2 680	Continued From page 12 setting for 1 of 1 resident (R30) reviewed for hospitalizations. Findings include: R30 was admitted to the facility on 10/15/24 after a hospitalization. R30's admission Minimum Data Assessment (MDS) dated 10/21/24, indicated R30 had moderate cognitive impairment, had no behaviors, needed set up for upper body dressing and eating, supervision for oral hygiene, needed supervision for lying to sitting, sitting to standing and transfers. R30 needed moderate assistance to move from a sitting position in bed to lying down in bed. R30's Clinical Diagnosis Report printed 1/23/25, indicated diagnoses of fracture of unspecified part of neck of left femur, subsequent encounter for closed encounter fracture with routine healing. Other diagnoses included supraventricular tachycardia (very fast and erratic heart bit), age related osteoporosis, history of falling, other symptoms and signs involving cognitive functional and awareness, non-celiac gluten sensitivity, autoimmune thyroiditis (a disorder in which the immune system attacks the thyroid), lymphedema (swelling due to build-up of lymph fluid in the body), not elsewhere classified, allergic rhinitis. As follows are the last four progress notes on R30's electronic chart: "General progress note: 10/30/24 at 1:31 p.m., indicated "Writer update SW team at United that we were willing to accept patient back once stable. However, that the family was opted to release the bed hold. She was private pay and needs a higher level of care. WWR SW spoke	2 680			

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2 680	Continued From page 13 with family, and they have released the bed hold with the goal of patient moving to a higher level of care vs STR then to another place. they want to limit the number of changes (moves) for her especially due to her cognition. This was all relayed to United SW on unit 4900." This note was authored by the facility's admission coordinator. "Bed hold note: 10/30/24 at 1:22 p.m., indicated "writer spoke with Deanna, daughter of resident. Family would like to release the bed for resident at this time." "Order administration note: 10/30/24 at 7:49 a.m., indicated "Apixaban oral tablet 2.5 mg give 1 tablet by mouth two times a day for post op dvt [deep vein thrombosis] prophylaxis." "Social Service Note: 10/28/24 at 8:15 a.m., indicated, "writer spoke with [name] from ALF re: an assessment into ALF [name] will be to the facility in 10/29 at 9 a.m. for an assessment." R30's progress notes lack documentation about why R30 was transferred to the hospital. During interview on 1/22/225 at 2:50 p.m., facility's admission coordinator (ADC) stated she didn't know why she was transferred to the hospital. ADC was able to print a record from the hospital which indicated R30 was brought to the hospital by her family. During interview on 1/23/25 at 9:15 a.m., licensed practical nurse (LPN)-A stated she did not remember R30, but whenever she sent a resident to the hospital, she needed to make a progress note, call the doctor and the family, and document everything in the chart. During interview on 1/23/25 at 9:26 a.m., LPN-B stated she didn't recall what happened to R30, but they always needed to document changes in	2 680			

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2 680	Continued From page 14 condition. During interview on 1/23/25 at 10:50 a.m., care coordinator/LPN-C stated anytime somebody went to the hospital the nurse will write a progress note and obtain a physician order. If it's urgent and the resident requires immediate transfer, the nurse will update the physician, call the family. This will need to be communicated during change of shift. Everything will need to be documented. LPN-C verified there was no documentation on R30's records about being transferred to the hospital. During interview on 1/23/25 at 12:32 p.m., director of nursing (DON) stated she remembered the family took her to the hospital. DON verified there was no documentation on R30's medical record indicating R30 was transferred to the hospital. Facility Policy titled Hospital Transfer dated 1/2025 indicated, facility will make every attempt to provide resident care and minimize the need to transfer residents to an acute care facility. The policy also indicated, hospital transfer orders may be obtained in writing or via telephone order and processed in a timely manner. Licensed staff will complete the hospital transfer document located in the electronic health record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise discharge summary procedures and provide education to staff in order to ensure completeness of the summary, as require. The DON or designee could conduct auditing of the discharge summaries to ensure compliance. The results could be brought to the quality committee	2 680			

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2 680	Continued From page 15 for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 680			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively reassess and demonstrate adequate justification for the continued use of an indwelling catheter for 1 of 2 residents (R4) reviewed who used a catheter. Further, the facility failed to develop a comprehensive plan of care to monitor and assess residents with indwelling catheters for 1 of 2 residents (R4) reviewed who used a catheter. The facility further failed to ensure a resident who was continent of bowel received services to maintain bowel continence for 1 of 2 residents (R5) reviewed for bowel and bladder.	2 830	Corrected		2/21/25

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2 830	Continued From page 16 Findings include: R4's admission Minimum Data Set (MDS), dated 1/9/24, indicated R4 was admitted to the care facility on 12/4/24, had severe cognitive impairment and was dependent on staff for bathing, toileting, and dressing. The MDS further indicated R4 had a Foley catheter on place. R4's Urology Consult Note, dated 12/27/24, indicated R4 had an indwelling Foley catheter placed by urology that day as R4 relied on daily intermittent catheterization (a process where the catheter is removed after each use vs an indwelling catheter which remains in place) managed by R4's wife who had difficulty performing catheterization while R4 was in the hospital. The Urology note indicated to "maintain Foley catheter at discharge, until patient is back to baseline or in 7-14 days. We can help arrange follow up to remove this otherwise okay for wife to deflate balloon and resume cathing 2-3 times daily after discharge." R4's Hospital Discharge note, dated 1/3/25, indicated "unable to straight cath on 12/27/24. Urology placed a Foley 12/27/24. Plan to discontinue Foley and resume intermittent straight cath with wife to manage at TCU [transitional care unit] per discussion with wife and TCU facility. R4's Physician Progress note, dated 1/6/25, indicated R4 had a comorbidity of urine retention due to Parkinson's Disease. The note further indicated "early discontinuation of Foley if present to help prevent CAUTI [catheter associated urinary tract infection] and initiation of intermittent straight catheterizations recommended. Initiate	2 830			

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2 830	Continued From page 17 timed voids and bladder training as indicated." R4's Physician Progress note, dated 1/20/25, indicated the same catheter recommendations from the note dated 1/6/25. R4's Physician Orders, dated 1/20/25, indicated an order for Ciprofloxacin (an antibiotic) 500 mg twice a day for 7 days for a urinary tract infection. During an interview on 1/22/25 at 11:00, the nurse coordinator (NC) stated she believed that R4's spouse had wanted the catheter to stay in place as she had been "running the show." The NC was unsure what the ongoing plan was for R4's catheter. During an interview on 1/22/25 at 12:44 p.m., R4's nurse practitioner (NP) stated that R4's Foley catheter was placed due to R4's spouse having a hard time with the intermittent straight catheterization for R4 and had requested a Foley catheter. During an interview on 1/23/25 at 11:35 a.m., the director of nursing (DON) and NC stated if there were no specific orders for a Foley catheter, the facility had standing orders to remove the Foley catheter and attempt a void trial (a procedure that assess a person's ability to urinate normally without a catheter.) During an interview on 1/23/25 at 1:09 p.m., R4's physician stated R4's spouse had been managing R4's intermittent straight catheterizations but that the care facility staff would be able to manage the catheterizations if necessary. The physician stated R4 would be moving to the assisted living next week and would "probably end up needing a long term cath[eter] with monthly changes."	2 830			

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2 830	Continued From page 18 A facility policy titled Catheter, revised 1/2025, indicated "Vivie will ensure that a resident who admits to a Skilled Nursing Facility (SNF) without an indwelling catheter will not be catheterized unless the resident's clinical condition demonstrates that catheterization is necessary; or that a resident who enters the facility with an indwelling urinary catheter or subsequently receives one, is assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization is necessary. " R5 R5's admission Minimum Data Set (MDS), dated 1/6/25, identified R5 was cognitively intact and required substantial/maximal staff assistance with toileting care. Further, the MDS outlined R5 as being always incontinent of bowel, however, a toileting program to manage the resident's bowel continence was marked no with a check mark. During interview on 1/21/25 at 8:57 a.m., R5 was observed lying in bed. R5 stated he would like to use the toilet instead of going in his incontinent pad for bowel movements. R5 stated he has a Foley catheter (a flexible tube that drains urine from the bladder into a bag). R5 stated staff does not offer to bring him to the bathroom and added, "they tell me they will just clean me up." R5 stated, "it is so unnatural to just go and get cleaned up." R5 stated his preference is to use the bathroom/toilet. R5's care plan, printed 1/23/25, identified the following:	2 830			

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2 830	Continued From page 19 - "TOILET USE: The resident is totally dependent on staff for toilet use." - "TRANSFER: The resident is totally dependent on staff for transferring." - "The resident is WEIGHT-BEARING." - "Encourage the resident to sit on the toilet to evacuate bowels if possible." - Ensure the resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible." R5's progress notes, dated 12/31/24 to 1/23/25, were reviewed and lacked evidence of a toileting program attempted. Furthermore, the progress notes lacked evidence of offering R5 the use of a toilet or a bed pan [a device used as a receptacle for the urine and/or feces of a person who is confined to a bed]. R5's Order Summary Report, printed 1/22/25, lacked evidence of toileting program. R5's Kardex, printed 1/21/25, indicated the following: - "Bladder/Bowel: Encourage resident to sit on toilet to evacuate bowels if possible." - "Toileting: Ensure the resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible." - "Mobility: The resident is WEIGHT-BEARING." - "Transferring: TRANSFER: The resident is totally dependent on staff for transferring." - "Toileting: TOILET USE: The resident is totally dependent on staff for toilet use." R5's care sheet, printed 1/21/25, indicated R5	2 830			

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NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II			STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From page 20 continent of bowel and bladder. Furthermore, indicated on EBP [enhanced barrier precautions] for Foley. R5's Nursing Assessment - Admission/Readmission, dated 12/31/24, indicated the following: R5 was occasionally incontinent of bowel. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and Kardex's to find the information needed to care for residents. NA-A indicated if they had any questions about resident cares/needs, they would ask the nurse. NA-A verified there was important information on the care sheets such as residents name, bath days, how they transfer, if they are continent or incontinent of bowel and bladder and other health information. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 needs staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week, adding "we go in and reposition him." NA-C stated R5's incontinent pad is check and changed when R5 is repositioned, verifying R5 has not been offered a bed pan or use of the bathroom or toilet. On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D verified R5 does not use the toilet or bed pan. NA-D verified they have not offered R5 a bed pan or toilet as R5 was to be repositioned and changed. NA-D indicated they have not transferred R5 "for a while" and were unable to give a time frame of the last time they assisted him transferring out of bed.	2 830			

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2 830	Continued From page 21 During a follow up interview on 1/22/25 at 2:50 p.m., R5 stated again staff had not offered to bring him to the bathroom which is what he prefers. R5 stated he has not been in the bathroom in his room. R5 stated he knows when he must have a bowel movement and when he tells staff they tell him they will clean him up after he goes. R5 stated he has not been offered any other options beside "getting cleaned up" after having a bowel movement. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated this would be added to the care plan. RN-B stated a resident would be offered the bathroom but if they couldn't use the bathroom, it would be expected the resident was offered a bed pan. RN-B verified R5's care plan did not have a preference to not use the bathroom, bedside commode or bed pan. On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care sheets, care plans, and Kardex to help determine resident needs. NA-B stated if they had questions about resident needs, they would ask the nurse. NA-B stated residents' preferences would be on their care plan. On 1/23/25 at 10:28 a.m., licenses practical nurse coordinator (LPN)-C verified R5's admission nursing assessment indicates R5 was continent of bowels with occasional incontinence. Furthermore, LPN-C verified R5's care plan indicates R5 was able to bear weight and dependent on staff for toileting needs. LPN-C stated the expectation would be staff would be assisting with toileting as R5's not independent. On 1/23/25 at 12:15 p.m., director of nursing	2 830			

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2 830	Continued From page 22 (DON) verified resident preferences and needs should be on resident's care plan. DON stated it is important "so we can provide the best care." On 1/23/25 at 1:21 p.m., RN-F verified they are familiar with R5. RN-F verified R5 has not been transferred out of bed in at least the last couple of weeks to use the bathroom. RN-F stated they were unsure if they were transferred out of bed prior to that. A facility policy titled Incontinence, revised 1/2025, indicated the following: "When deemed appropriate, Vivie staff will implement interventions that may promote achieving the highest practicable level of functioning, may prevent the development of incontinence, or minimize a decline or lack of improvement in degree of continence include providing treatment and services to address factors that are potentially modifiable, such as: a. Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, neurological impairments, etc. b. Removing or improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode or reducing the distance to the toilet); c. Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion); d. Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration); and e. Implementing a fluid and/or bowel management program to meet the assessed	2 830			

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21375	Continued From page 24 3 residents (R4) on enhanced barrier precautions (EBP) reviewed for proper PPE use during survey. In addition, the facility failed to ensure a comprehensive Infection Prevention and Control Program (IPCP) was maintained to include an ongoing analysis of collected data to help identify and reduce the risk of infection spread and outbreak. This had potential to affect all 30 residents, staff, and visitors. Findings include: R4's admission Minimum Data Set (MDS), dated 1/9/25, indicated R4 was dependent on facility staff for bathing, toileting and dressing and had a Foley catheter in place. During observation on 1/22/25 at 9:05 a.m., nursing assistant (NA)-E and NA-F entered R4's room. A sign was posted on R4's door indicating R4 was on enhanced barrier precautions (EBP) indicating staff must wear gown and gloves when providing "high contact resident care activities" including bathing, dressing, transferring and brief changes. NA-E and NA-F did not don appropriate PPE when they failed to wear a gown while providing high contact activities. NA-E and NA-F donned gloves and provided R4 with a partial bed bath, brief change and peri care, transferred him to his recliner chair via a mechanical lift. R4 was observed to have a Foley catheter in place with a drainage bag hanging on the side of the bed. NA-F emptied the urine in R4's drainage bag into a graduated cylinder. During all cares, neither NA-E nor NA-F were observed to wear a gown. During an interview on 1/22/25 at 1:43 p.m., R4's family member (FM)-A stated she did not see staff wearing gowns "very often", stating therapy staff were often wearing gowns but otherwise she	21375			

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21375	Continued From page 25 did not see staff wear gowns. During an interview on 1/22/25 at 1:47 p.m., NA-F stated R4 was on EBP because he had a Foley catheter and that she was aware she should have had a gown on when providing cares but "forgot". During an interview on 1/22/25 at 11:00 a.m., the nurse coordinator (NC) and director of nursing (DON) stated that all staff should be wearing gloves and gowns when providing care in residents' rooms on EBP, stating it was important to prevent the spread of infection. SURVEILLANCE The facility' infection control program, including surveillance and analysis data, was requested. The following was provided: a white three ring binder titled "Infection Prevention Resource Manual." The binder lacked any specific data related to the facility. Furthermore, the binder lacked any surveillance data or analysis data of the facility. During an interview on 1/22/25 at 1:46 p.m., director of nursing (DON) stated she was currently the acting facility infection preventionist and was responsible for overseeing the infection control program. DON verified there was no current surveillance of infections, resident symptoms or tracking of antibiotic use. DON stated she was unable to provide any current type of surveillance or data analysis. DON stated there are currently no audits being completed of staff adherence/proper use of PPE or handwashing. DON stated the facility was currently not tracking resident antibiotic use to ensure proper use and follow up, tracking of prophylactic antibiotics to	21375			

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21375	Continued From page 26 ensure proper use and follow up and she was unaware if any antibiotic time-outs were occurring. During a follow up interview on 1/23/25 at 8:49 a.m., DON verified there are currently no antibiotic time-outs occurring at the facility. A facility policy titled Infection Control Surveillance, revised 1/2025, indicated "The Infection Preventionist (IP) or Director of Nursing (DON) will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions." Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all illnesses in the facility as well as an antibiotic stewardship program, immunization program and qualified infection preventionist. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375			

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21426	Continued From page 28 residents must receive a baseline TB screening. The baseline TB screening should consist of an assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for infection with mycobacterium tuberculosis. In addition to screenings, the residents and employees were to receive a two-step tuberculin skin test (TST) or a laboratory screening for TB. The results should be read by a trained health care worker 48-72 hours after tuberculin skin test (TST) was administered, with the second-step TST being administered 1-3 weeks after the first TST result was read. If an employee or resident tested positive for any of the aforementioned tests, a chest x-ray, and/or medical examination by a medical practitioner was to be completed to rule out active disease. R26 R26's admission Minimal Data Set (MDS), dated 12/16/24, indicated R26 was admitted to the care facility on 12/10/24 and was cognitively intact. R26's January Medication Administration Record (MAR/TAR), printed 1/22/25, indicated the following: -TB step 1 administered on 1/1/25 and was read on 1/3/25 with no results recorded. -TB step 2 administered on 1/11/25 and was read on 1/13/25 with no results recorded. R26's immunization record, dated 1/23/25, indicated the first step of the TST was administered on 12/14/24 and the results were "pending". The record indicated another TST was administered on 12/24/24 and the results were "pending". Furthermore, the record indicated another TST was given on 1/11/25 and the results were pending. The record did not indicate R26 had a completed two-step TST.	21426			

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21426	Continued From page 29 R26's electronic medication record (EMR) reviewed and lacked evidence of a completed two-step TST. R28 R28's entry tracking MDS, dated 1/7/25, indicated R28 admitted to facility on 1/7/25. R28's January MAR/TAR, printed 1/23/25, indicated the following: -TB step 1 administered on 12/24/24 and was read on 12/27/24 with no results recorded. -TB step 2 administered on 1/7/25 and was read on 1/9/25 with no results recorded. R28's immunization record, dated 1/23/25, indicated the first step of the TST was administered on 12/24/24 and the results were "pending". The record indicated another TST was administered on 1/7/25 and the results were "pending". The record did not indicate R28 had a completed two-step TST. R28's progress notes, dated 12/22/24 to 1/22/25, lacked evidence of results of TST administered. R133 R133's entry tracking MDS, dated 1/16/25, indicated R133 admitted to the facility on 1/16/25. R133's January MAR/TAR, printed 1/23/25, indicated the following: -TB step 1 was ordered to be administered on 1/16/25 and not administered. R133's immunization record, dated 1/23/25, indicated the first step of the TST was administered on 1/22/25 and the results were "pending". The record did not indicate R133 had a	21426			

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21426	Continued From page 30 completed two-step TST. R133's progress notes, dated 12/24/24 to 1/24/25, lacked evidence of R133 not needing a two-step TST or completing one TST test. R233 R233's admission MDS, dated 1/19/25, indicated R233 admitted to the facility on 1/13/25. R233's January MAR/TAR, printed 1/23/25, indicated the following: -TB step 1 administered on 1/14/25 and was read on 1/15/25 (24 hours after administration) with no results recorded. R233's immunization record, dated 1/23/25, did not indicate a TB within the 3 months. On 1/22/25 at 10:13 a.m., licensed practical nurse (LPN)-A verified all residents are tested for TB using a 2-step Mantoux. LPN-A verified the screening for TB was completed during the nursing assessment to screen for symptoms of TB. LPN-A indicated administrations for TB tests are signed off on the MAR and results would be documented. LPN-A verified TB tests are given about 2 weeks apart and the reading of the results are "like 72 hours" after administration. On 1/23/25 at 8:33 a.m., director of nursing (DON) verified the two-step Mantoux is used to test residents for TB. DON stated the TB tests and results would be on the immunization record in residents' electronic medical record (EMR). After reviewing R26, R28, R133, and R233 EMR's, DON verified the following: -R26 had 2 TB tests administered (1/3/25 and 1/13/25) with no results recorded -R28 had 2 TB tests administered (1/7/25 and	21426			

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21426	Continued From page 31 1/9/25) with no results recorded. -R133 did not have her TB test administered until after record review. DON added, "we had an issue getting the tuberculin but I am not sure if that affected hershe did get the first step administered now" -R233 had TB test administered on 1/14/25, read on the 15th with no results recorded. DON verified the TST test was not read within the 48-72-hour time frame. DON verified these residents did not have a completed the 2-step Mantoux TST and stated it is important to administering and recording Mantoux tests and results accurately. A facility policy titled Tuberculosis Screening for Residents, revised 1/2025, indicated "All residents admitted to Vivie TCU/LTC communities must receive a baseline Tuberculosis (TB) screening within 72 hours of admission. TB screening includes an assessment of the resident's risk factors for TB, any current TB symptoms, and one of the following options: a 2-step Mantoux Tuberculin Skin Test (TST), a chest x-ray, or QuantiFERON blood test, as indicated." SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance	21426			

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21426	Continued From page 32 Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426			
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After	21830			2/21/25

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21830	Continued From page 33 notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the	21830			

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21830	Continued From page 34 admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident choices for bathing preferences were assessed and honored for 1 of 1 residents (R5) reviewed for choices. Findings include: R5's admission Minimum Data Set (MDS), dated 1/6/25, indicated R5 had intact cognition with no hallucinations or delusions. On 1/21/25 at 8:57 a.m., R5 indicated he has only been out of bed one time since admission to the facility. R5 indicated he was transferred out of bed with assist of 2 staff and walker and back to bed with a Hoyer lift (mechanical lift/device that lifts patients from one place to another who cannot bear weight on their lower extremities). R5 indicated he was currently receiving hospice	21830	Corrected		

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NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II			STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21830	Continued From page 35 services. R5 indicated staff come in and "wash me up and rotate me" but has not had a shower since admission which he prefers. R5's care plan, printed 1/23/25, identified the following: -"BATHING/SHOWERING: The resident requires assistance from 1 staff with bathing." -"TRANSFER: The resident is totally dependent on staff for transferring." -"PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on staff for personal hygiene and oral care." -"The resident is WEIGHT-BEARING." -"AMBULATION: The resident does not ambulate." R5's care plan lacked evidence of R5's preference to have a shower versus a bed bath. R5's care sheet, printed 1/21/25, lacked evidence of preference of bathing preferences: showers vs baths. R5's Kardex, printed 1/21/25, identified the following: -"Bladder/Bowel: Encourage resident to sit on toilet to evacuate bowels if possible." -"Toileting: Ensure resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible." -"BATHING/SHOWERING: The resident requires assistance from 1 staff with bathing." -"TRANSFER: The resident is totally dependent on staff for transferring." -"PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on staff for personal hygiene and oral care." R5's Kardex lacked evidence of R5's preference	21830			

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21830	Continued From page 36 to have a shower versus a bed bath. R5's progress notes, dated 12/31/25 to 1/23/25, were reviewed. R5's progress notes lacked evidence of an assessment or conversation of R5's choice for bathing preference. R5's Nursing Assessment Admission/Readmission, dated 12/31/25 was reviewed and identified the following: -"Bathing Preference/Day/Shift" marked "ADL-Bathing Monday and Thursday PM" R5's Nursing Assessment lacked evidence of assessment of R5 being offered a choice between a bed bath and shower. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and Kardex's to find the information needed to care for residents. NA-A indicated if they had any questions about resident cares/needs, they would ask the nurse. NA-A verified there was important information on the care sheets such as residents name, bath days, how they transfer, if they are continent or incontinent of bowel and bladder and other health information. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 requires staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week. NA-C verified they have not assisted R5 with a shower, adding "hospice has been doing his bed baths," and verified showering was a responsibility of nursing assistants. NA-C was unable to indicate whether R5 preferred a bed bath or a shower. NA-C stated the care plan indicates that R5 needs assist of 1 staff.	21830			

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21830	Continued From page 37 On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D indicated they have not transferred R5 "for a while" and were unable to give a time frame of the last time they assisted. NA-D indicated they "think he is a Hoyer". NA-D indicated they are not sure when hospice comes to see R5 and stated, "there is a schedule for hospice I think." NA-D indicated they have not assisted R5 with a shower. During a follow up interview on 1/22/25 at 2:50 p.m., R5 verified they prefer a shower. R5 stated he has not been offered a shower since admission. R5 added he doesn't know if there was a shower in the bathroom as he has not been in the bathroom in his room before. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated this would be added to the care plan. RN-B stated that if a resident has a preference to have a bed bath versus a shower, that would have been assessed and added to the care plan for continuity of care. RN-B verified R5 was on hospice. On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care sheets, care plans, Kardex to help determine resident needs. NA-B stated if they had questions about resident needs, they would ask the nurse. NA-B stated if it was resident's preference to have a bed bath versus a shower, that would be on the care plan and stated, "an aid cannot decide this." NA-B stated an aide's job is to "help the resident, wash the resident if needed, change the resident, you make beds, give them the call lights." NA-B stated residents' preferences would be on their care plan such as if they prefer to stay in bed or if	21830			

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21830	Continued From page 38 they want a bed bath or a shower. On 1/23/25 at 10:08 a.m., licenses practical nurse coordinator (LPN)-C indicated residents should be given choices regarding their cares and their preferences are put on their care plans. LPN-C reviewed R5's assessments and care plan. LPN-C verified R5's electronic medical record (EMR) lacked evidence R5 was provided choices regarding showers versus baths. Furthermore, LPN-C verified R5's care plan indicates R5 was able to bear weight and dependent on staff for transferring. LPN-C verified R5 was not assessed by physical therapy or occupational therapy as "[R5] is on hospice." LPN-C stated it is important that residents have choices as, "it is their right to make choices ...we are taking care of them ...we want to meet their needs and provide the best care we want to accommodate that to the best of our ability." On 1/23/25 at 12:15 p.m., director of nursing (DON) verified a resident should be assessed for preferences and the preferences would be on a resident's care plan. DON verified if a resident has a preference to have a shower or a bed bath, that would be on a care plan as that would have been assessed. A facility policy on resident choices was requested and not received. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure	21830			

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21830	Continued From page 39 compliance. The results of those audits should be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830			
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure private and confidential resident information was secure and not visible to residents and visitors when multiple care sheets were left out in public view. This had the ability to affect eleven residents on the 400 hallway including R4. Findings include: During observation on 1/21/25 at 12:17 p.m., a medication cart down the 400 hallway was left unattended with a care sheet out in public view	21855	Corrected		2/21/25

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21855	Continued From page 40 which identified five patient rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. Multiple residents were seen wandering by the unattended medication cart with resident private information in sight. During an interview on 1/21/25 at 12:27 p.m., registered nurse (RN)-D stated he was working from the medication cart that day and due to the private resident information on the care sheets, they should be tucked away under the computer or behind the nursing desk so it was not out and visible to residents or visitors. During observation on 1/21/25 at 9:48 a.m., a clip board was observed sitting on the edge of the unit desk with a care sheet "cart 1" out in public view which identified five resident rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. Multiple residents and family members were seen wandering by the unattended clip board with resident private information in sight. At 9:53 a.m., registered nurse (RN)-E was observed to pick up the clip board that contained the care sheet. On 1/23/25 at 8:22 a.m., it was observed medication cart 3 was left unattended in the hallway outside a room with the computer screen open with R4's medication orders on the screen along with a care sheet out in public view. The	21855			

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21855	Continued From page 41 care sheet labeled "cart 3" identified six resident rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. There was no nurse in the area. At 8:25 a.m., licensed practical nurse (LPN)-A came out of a resident room stating, "Oh my, did I leave that open?" when asked about the computer screen. LPN-A verified the screen was left open and unattended with resident information viewable and verified they were working on medication cart 3. LPN-A grabbed the care sheet when asked to verify what the sheet was titled and placed it in their pocket stating, "it is always in my pocket." LPN-A verified the sheet had resident information on it. On 1/23/25 at 10:30 a.m., licensed practical nurse coordinator (LPN)-C stated it is important to keep resident information private. LPN-C stated the expectation was that resident information is not to be left out in public view and any papers are to be flipped over and computer screens should be locked when not in use. A facility policy titled Notice of Privacy Practices, revised 1/2025, indicated "we are required by law to maintain the privacy and security of your protected health information." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality of records. All staff could be educated as necessary to the	21855			

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21855	Continued From page 42 importance of complaine with handling and securing medical records. The DON or designee, could perform observational audits to ensure staff are locking access to medical records when not physically present. The DON or designee could take that information to QAPI to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21855			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on January 22, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Walker Methodist Wedgewood Ridge II, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/13/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Walker Methodist Westwood Ridge II is a 1-story building with a partial basement. The facility was constructed in 2012 and was determined to be of Type V(111) construction. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridors and is monitored for automatic fire department notification.	K 000			

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

PRINTED: 02/14/2025
FORM APPROVED
OMB NO. 0938-0391

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K 000	Continued From page 2	K 000			
K 324 SS=F	The facility has a capacity of 36 beds and had a census of 30 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 324		3/4/25	

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K 324	Continued From page 3 Based on observation and staff interview, the facility failed to maintain commercial cooking equipment per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.2.6, and NFPA 17A (2009 edition), Wet Chemical Extinguishing Systems, section 4.3.1.5. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 01/22/2025, between 9:00 AM and 11:30 AM, it was revealed by review of available documentation and staff interview that in March of 2024, the fusible links in stalled were of different temperatures than those installed in September of 2024. (in March, a 1 360 degree, 3 450 degree and 0 500 degree fusible links were installed. In September of 2024, 4 360 degree, 0 450 degree and 2 500 degree fusible links were installed) An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 324	The facility notified the contracted fire suppression company, Summit, of the temperature discrepancy. Summit informed the facility that the Ancil fire suppression equipment had not been set to alternate temperatures as their report of March 8th, 2024, indicated. Summit confirmed that the technician that completed the report did so in error and that technician is no longer with the fire suppression company. Maintenance Director or designee will ensure that cooking equipment is protected in accordance with NFPA 96. Maintenance Director or designee will audit accuracy of reports submitted by a contracted fire suppression company for one year. The results of these audits will be shared with facility QAPI committee for input on need to decrease, or discontinue audits.		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351			3/4/25

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NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II			STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
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K 351	Continued From page 4 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/22/2025 between 9:00 AM and 11:30 AM, it was revealed by observation that there was flex conduit strapped to the sprinkler supports and additional wires observed resting on the sprinkler system above the ceiling near the 1st floor rest rooms. This was observed in two locations in this area. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 351	The conduit identified to be strapped to the sprinkler supports along with any additional wires observed resting on the sprinkler system corrected. Any staff or contractors accessing the ceiling will be prohibited from attaching conduits and wires to the sprinkler system supports. Maintenance department educated on not attaching conduits and wires to the sprinkler system supports. Maintenance Director or designee will audit sprinkler system supports to ensure they are free from conduits and wires bi-annually. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920			3/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245618		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2025	
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II				STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118			
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K 920	Continued From page 5 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 1/22//2025 between 9:00 AM and 11:30 AM,			K 920	The power-strip in the salon was immediately removed. The licensed salon owner was educated on the use of power-strips with electrical appliances. Audit conducted to ensure no further inappropriate use of power strips on the TCU. All staff educated on power strip use. Maintenance Director will audit 5 random		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245618	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST WESTWOOD RIDGE II			STREET ADDRESS, CITY, STATE, ZIP CODE 61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118		
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K 920	Continued From page 6 was revealed by observation that there were several electrical appliances (hair dryer and curling iron) plugged in a power-strip in the Solon on the 1st floor. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 920	areas on TCU weekly x 4 weeks to ensure no inappropriate use of power strips. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 13, 2025

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: CCN: 245618
Cycle Start Date: January 23, 2025

Dear Administrator:

On March 12, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 13, 2025

Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: Reinspection Results
Event ID: J34I12

Dear Administrator:

On March 12, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 23, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us