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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KIMX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00276

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245055**

2.STATE VENDOR OR MEDICAID NO.
(L2) **202742900**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/08/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
02/28

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

12.Total Facility Beds **336** (L18)

13.Total Certified Beds **336** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	314	22		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 03/18/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/08/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/29/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/08/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5055

At the time of the standard survey completed January 17, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On March 4, 2013, the Minnesota Department of Health and, on March 8, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on January 17, 2013, effective March 4, 2013. Therefore, the remedies outlined in our letter dated January 29, 2013, will not be imposed. See attached CMS-2567B forms for the results of the March 4, 2013 and March 8, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN# 24-5055

April 8, 2013

Ms. Karly Lewis, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

Dear Ms. Lewis:

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

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

Effective March 4, 2013 the above facility is certified for:

314 Skilled Nursing Facility/Nursing Facility Beds

22 Nursing Facility I Beds

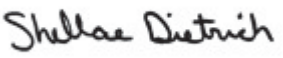
Your facility's Medicare approved area consists of all 314 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 18, 2013

Ms. Karly Lewis, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

RE: Project Number S5055023

Dear Ms. Lewis:

On January 29, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 17, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 8, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 17, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 17, 2013, effective March 4, 2013 and therefore remedies outlined in our letter to you dated January 29, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Shellae Dietrich
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5055r113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245055	A. Building B. Wing	3/4/2013

Name of Facility	Street Address, City, State, Zip Code
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **03/04/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/04/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/04/2013**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/04/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/04/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/sd	03/18/13	15507	03/04/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
1/17/2013	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245055	A. Building B. Wing 01 - BUILDING 01	3/8/2013

Name of Facility	Street Address, City, State, Zip Code
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	02/26/2013	ID Prefix Reg. # NFPA 101 LSC K0147	02/26/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/sd	Date: 03/18/13	Signature of Surveyor: 28120	Date: 03/08/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/15/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KIMX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00276

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245055**

2.STATE VENDOR OR MEDICAID NO.
(L2) **202742900**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/17/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
02/28

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

12.Total Facility Beds **336** (L18)

13.Total Certified Beds **336** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	314	22		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NE II 02/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/01/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/8/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN# 24-5055

At the time of the standard survey completed January 17, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5440

January 29, 2013

Ms. Karly Lewis, Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, Minnesota 55409

RE: Project Number S5055023

Dear Ms. Lewis:

On January 17, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3794

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 26, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 17, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 17, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

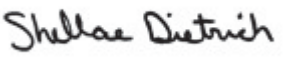
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5055s13.rtf

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	01/17/2013

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

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			Walker Methodist Health Center provides innovative, technically competent, effective, sensitive, individualized care and programs. We value the dignity and uniqueness of each individual and strive to maintain their autonomy and independence while providing a safe and secure environment. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest of Facility, its Administrator or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegation of non-compliance or admission by Facility.	

RECEIVED
FEB 11 2013
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

POC accepted 2/14/13 KFantto

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

Karen Jensen | Administrator | 2/6/13

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	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to make prompt efforts to resolve residents' complaints and to provide a resolution of the complaint for 4 of 4 residents (R29, R86, R137 and R267) in the sample who verbalized unresolved complaints. Findings include: R29 complained about disrespectful treatment, mattress discomfort, noise at night, and fruit flies R86 complained about staffs' condescending attitude, personal cell phone use, and use of languages other than English. R137 complained about disrespectful treatment. R267's friend	F 166	Walker Methodist Health Center does make prompt efforts to resolve grievances the residents may have, including those with respect to the behavior of other residents. Corrective Action: Facility will post in public area Issue and Concern Forms and procedure for submission by 2/26/13. Facility will review and revise facility policy and Issue and Concern form. All utility room doors on 4 Gamble have been checked and repaired as needed. Facility pest control contractor was here on 1/31/13 with further follow up scheduled. Social Services will maintain the issue and grievance log and report at Quality Assurance meetings. Identification of other residents: Quality rounds will be conducted weekly through 2/26/13 in addition to regularly scheduled quality audits to ensure correction of cited deficiency.	2/26/2013

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

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F 166	Continued From page 1 complained about concerns with various problems in the resident's room and with care. All of the individuals stated that although their concerns were voiced, the issues had not been resolved. R29 stated in an interview on 1/15/12, at 12:40 p.m. "There is one guy on the day shift--he said something derogatory to me one time. He said, 'Don't be asking me to do everything now. I'm not going to do it.' and I reported him to [nurse manager] during a resident council meeting." R29 said the registered nurse manager (RN)-A was informed, "There is too much teasing in the dining room and it is not always appropriate." R29 further stated, "When I do complain, they never get back to me so I don't know if it does any good. I have complained of the utility door noise outside my room at night and it still keeps happening." R29 stated that although the mattress on the bed had been replaced, it was still too hard and she had padded the mattress with pillows. R29 "continued wishing" for a softer mattress. On 1/16/12, at the noon meal, R29 stated, that the "Fruit flies are still here that I told them about in the resident council meeting." On 1/15/13, at 4:30 p.m. RN-A verified R29 had reported the concerns about noise at night from the utility door, but said because the concerns were not written formally, there was no follow up regarding the issues. RN-A stated he had informed the night staff of the complaints about the utility door, but there was no documentation regarding the concern. Interviews with night shift staff were conducted on 1/17/13, at 6:20 a.m. with RN-B, and nursing	F 166	Measures put in place: Staff will be re-educated on need to treat residents with respect, to include: maintaining low noise level at night, use of personal cell phones, speaking in a language other than English,maintaining a positive attitude, etiquette in the dining room during meals, responding to resident call lights, and maintaining resident dignity by covering resident catheter bags. Staff will be provided education on the changes to the policy and procedure for issues and concerns. Monitoring performance: Audit findings will be brought to the Quality Assurance committee for review and recommendations of further actions. Responsible for the plan of correction: Social Services, ADON or designee	

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F 166	Continued From page 2 assistants (NAs) D and E. None of the staff were aware R29 voiced complaints about noise at night, nor did they know where Grievance/Concern forms were located or what they looked like. Later at 6:45 a.m. NA-A, NA-B, NA-C and the health information coordinator (HIC) from the day shift also stated they did not know where to find Grievance/Concern forms, did not know what they looked like, and had never utilized the forms. R86 stated in an interview on 1/14/13, at 1:47 p.m. "There is a condescending attitude here with the staff. They do not treat us like we are important. The aides talk on the cell phone when they are suppose to be doing cares, and sometimes they speak in their language which isn't English. I don't feel they get back to me when I express a complaint. I speak up but no one does anything about it." The resident explained that concerns were reported numerous times, but now felt mentioning something might make the situation worse. R86 stated, "It is easy to believe someone will help us, protect us, help our anxieties, but our responses are not addressed and they do not get back to us." On 1/15/13, at 4:30 p.m. RN-A acknowledged awareness of R86's complaints regarding cell phones as well as the English language concern. RN-A stated he had addressed the situation with staff, but had not documented the follow up. R137 stated on 1/14/13, at 3:45 p.m. "[Nursing assistant (NA)-F] is very condescending to me. I asked if she was [NA-F's name] and she says, '[NA-F's name]? [NA-F's name] [NA-F's name] Who? Why are you calling me [NA-F's name]?'	F 166		

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F 166	Continued From page 3 She acted like it was a big game." R137 further reported, "I told [RN-A] about the guy who came in on the night shift, turned on my light and tried to change me when they need to leave me alone at night. I don't know what happened with that. It was a couple days ago." R137 also reported, "I have a concern in the dining room because there is too much teasing sometimes--not respectful and they carry it too far." The following day at 2:00 p.m. R137 stated a pain pill was requested, but when NA-F came to answer the call light at noon, she was rude and said, "'You have your light on!'" R137 then requested a pain pill, but found out later the NA never reported the request to the nurse. The resident questioned why management did not do something about the NA. On 1/15/13, at 4:30 p.m. RN-A acknowledged he was aware of R137 concerns, but had not documented the concerns and a response. R267's concerned friend (CF-A) contacted the survey team on 1/16/13, at 4:00 p.m. regarding unresolved concerns that the friend said had been reported to RN-C. The friend repeatedly complained about the head of the bed not being elevated, the resident being uncovered, the urine catheter bag being uncovered, the side rails being left down, and the bed not being in the low position. On 1/17/13, at 2:30 p.m. R267 was napping in bed with the head of the bed elevated 30 degrees. The resident and the urine bag were both covered. The friend was present and stated, "Today is a good day and everything looks good, but there are days that are not good and I don't understand why." After the observation, an interview was conducted with RN-C. The RN had several pieces of paper with notes regarding meetings with R267's friend, however, the RN	F 166		

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F 166	Continued From page 4 had no documentation to show the concerns had received follow up. On 1/16/13, at 3:00 p.m. the licensed social worker (LSW)-C explained concern forms were not always utilized when residents had concerns if the concerns were addressed by the unit staff. A Suggestion/Concern Log Record 2012 revealed 15 concern forms had been logged. Concerns expressed by R29, R86, R137 and R267 were not logged or were reported to LSW-C who was responsible for keeping track of concerns. A Formal Concern/Grievance policy dated 8/30/12, indicated residents and their families were "encouraged to share concerns/grievances regarding their experience" at the facility without fear of discrimination or reprisal. Concerns would then be "addressed in a timely manner." At the time of admission, the resident/family members would be informed of the procedure and the forms would be made available on each unit/from any manager. The manager was then responsive to review the forms, resolve the issue in a timely manner, and contact the individual with the concern within two days to obtain additional information if needed. A plan of action would then be put into place within seven working days and the complainant would be notified of the plan. Follow up would take place to determine the effectiveness of the plan. The concern form and documentation would be returned to the director of social services, associate administrator or administrator. Quarterly reports would be brought by managers to the Quality Improvement Committee with follow up as necessary.	F 166		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 5 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to coordinate hospice services with facility services for 2 of 4 residents (R416 and R387) reviewed for hospice services. Findings include: R416's facility care plan was not integrated with the hospice agency's care plan to ensure coordination of services. The type of services were not identified on the facility care plan, but were identified on a separate hospice care plan.	F 279	Walker Methodist Health Center does develop comprehensive care plans for the purposes of providing services that attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. In addition, the coordination of outside services are included in the comprehensive care plan for each resident as identified by the comprehensive assessment. Corrective Action: R416's care plan has been reviewed and revised to include integration of hospice services with facility services. R416's care plan was located and returned to the chart. Educational meeting scheduled for 2/10 with facility nurse managers and hospice providers to review process for integration of care plans. R387's care plan has been reviewed and revised to include integration of hospice services with facility services. All nursing staff will be re-educated on the relationship of hospice services to facility provided services. Facility will develop an audit tool to ensure integration of facility and hospice services. Identification of other residents: All hospice resident records will be audited to ensure inclusion of comprehensive hospice care plan by 2/26/13.	2/26/2013

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F 279	Continued From page 6 The hospice care plan revealed R416 was receiving the following hospice services: skilled nurse, home health aide, chaplain, and social services. Hospice was initiated for R416 on 11/19/12 when the resident experienced a significant change according to a completed Minimum Data Set (MDS). Although the medical record indicated R416 had a care plan from hospice, the record lacked a facility care plan. In addition, the medical record had notes from the hospice skilled nurse, chaplain, and social worker, but lacked notes from the home health aide (HHA). On 1/17/13, at 12:35 p.m. heath unit coordinator (HUC)-A verified there was no facility care plan in the chart, no HHA notes, or a hospice schedule in R416's medical record. On 1/17/13, at 12:00 p.m. a nursing assistant (NA)-B was asked about hospice services for R416. NA-B stated R416 received a shower from a hospice HHA, but NA-B did not know how often or on which days of the week hospice services were provided. At 12:50 p.m. the registered nurse (RN)-F was asked about hospice services for R416. RN-F stated this was the first day of working with R416. RN-F stated she knew which hospice provided services for R416, but would have to look up the hospice staffing schedule for other types of services provided and when they were to be provided. RN-F also stated a hospice nurse had just been in to see R416. On 1/17/13, at 12:40 p.m. RN-A verified the lack of HHA documentation in R416's medical record and the lack of a hospice staffing schedule. At	F 279	Measures put in place: Care plans will be audited quarterly with regularly scheduled care conferences and upon initiation of hospice services by the nurse manager to ensure a comprehensive hospice care plan. Monitoring performance: Audit findings will be brought to the Quality Assurance committee for review and recommendations of further actions. Responsible for the plan of correction: ADON or designee	

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F 279	Continued From page 7 1:15 p.m. RN-A reported the staff was looking for R416's facility care plan, and at 3:00 p.m. RN-A provided a copy of the plan. R416's care plan dated 11/6/12, revealed a handwritten note was added to the care plan dated on 11/10/12, and read, "Admitted to Allina Hospice." The care plan failed to contain any additional information about hospice services and/or the type of hospice services being provided to R416. The facility did not develop a care plan at the time hospice was initiated for R387. R347's significant change MDS assessment was initiated on 11/13/12, which indicated the resident was cognitively intact. Physician orders dated 1/10/13, directed staff to admit the resident to hospice with diagnoses of congestive heart failure (CHF) with history of myocardial infarction (heart attack). On 1/17/13, at 9:57 a.m. R387 was asked about hospice services, to which the resident responded, "I don't know what you are talking about." The hospice schedule in the medical record indicated the following services were to be provided: nurse 1-3 visits as needed per week on Monday and Thursday, hospice aide 1-3 times per week, and chaplain once a month. The facility resident care group sheet for R387 did not include hospice care or services. The facility care plan reviewed on 11/13/12, had not been updated to include hospice services or refer staff to a hospice care plan. The medical record also lacked evidence of a hospice agency care plan to include a hospice nursing aide care plan.	F 279		

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F 279	Continued From page 8 When interviewed regarding hospice services for R387 on 1/17/13, at 9:41 a.m. a nursing assistant (NA)-B stated "I don't know if she is on hospice." A registered nurse (RN)-F was a "float nurse" and said on 1/17/13, at 10:00 a.m. was unsure if the resident was on hospice, but said, "I can certainly find out for you." The RN reviewed R387's record and confirmed the resident was receiving hospice services. On 1/17/13, at 10:12 a.m. RN-A explained that R387's facility and hospice care plans would be coordinated at the resident's upcoming care conference meeting on 1/23/13, including the nursing assistant portion of the plan. RN-A further stated hospice had just been initiated on 1/10/13. At 1:14 p.m. RN-A provided a copy of the faxed care plan from the hospice agency.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents	F 315	Walker Methodist Health Center does follow a resident's comprehensive assessment to ensure that residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. In addition, Walker Methodist Health Center does assess all residents toileting needs and provides care in accordance with their assessed need. Corrective Action: Staff person that failed to follow resident 454's toileting care plan was provided re-education on 2/4/13.	2/26/2013

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F 315	Continued From page 9 (R454) in the sample reviewed for urinary incontinence, received the necessary care and treatment to minimize incontinence. Findings include: R454 was not toileted checked/changed every two hours according to the toileting plan. R454 was observed sitting up in a wheelchair at the dining table on 1/16/13, from 8:30 until 10:00 a.m. From 10:00 until 10:50 a.m. remained in the dining area and attended an activity in the west end. At the conclusion of the activity, the resident sat back at the dining table in the east end of the room. At 11:35 a.m. the surveyor intervened and notified a registered nurse (RN)-A of the three hour time span that the resident had not received toileting services. The RN contacted a nursing assistant (NA)-F to provide toileting. R454's incontinent brief was observed to be wet with urine, and the NA confirmed the resident had not been toileted for over three hours. R454's Bowel and Bladder Quarterly Summary dated 12/1/12, revealed "Resident is incontinent of bowel and bladder. To be toileted every two hours." An undated nursing assistant assignment sheet directed staff to "Toilet every two hours." R454's quarterly Minimum Data Set (MDS) dated 12/1/12, indicated the resident was frequently incontinent and required extensive assistance of two persons to use the toilet. The resident's care plan dated 1/2/13, read "Daily decision making requires staff to assist with daily decisions with activities of daily living. Communication difficult due to aphasia [speech disorder]."	F 315	Identification of other residents: Facility will audit 5% of incontinent residents to assure completion of assigned toileting schedule. Quality rounds will be conducted weekly through 2/26/13 in addition to regularly scheduled quality audits to ensure correction of cited deficiency. Measures put in place: All nursing staff will be re-educated on the need to complete toileting assignments per resident needs. Monitoring performance: Audit findings will be brought to the Quality Assurance committee for review and recommendations of further actions. Person responsible for plan of correction: ADON or Designee.	

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F 315	Continued From page 10 On 1/16/13, at 11:35 a.m. RN-A verified R454 should have been toileted every two hours according to the toileting assessment and plan. At 11:40 a.m. NA-F verified R454 was not toileted for over three hours, and resident was incontinent. On 1/17/13, at 7:55 a.m. therapeutic recreation staff person (TR)-A verified R454 attended an activity the previous morning from 10:00 until 10:50 a.m. and TR-A wheeled R454 back to the dining room table.	F 315		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal 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 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal 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 legal 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	F 334	F334 Walker Methodist Health Center has current policies and procedures to ensure that before offering the influenza immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization. Corrective Action: All nursing station file drawers will be audited and any old flu information sheets will be removed and replaced with current information. Identification of other residents: Any residents receiving flu vaccines from the time of the survey through the end of the flu season shall receive the 2012-2013 flu vaccine information sheet. Measures put in place: All outdated forms have been destroyed. Monitoring performance: Nurse managers will audit file cabinets to ensure that all old documentation has been removed from the file.	2/26/2013

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	245055	A. BUILDING _____ B. WING _____	01/17/2013

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F 334	Continued From page 11 contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal 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 legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	Person responsible for plan of correction: ADONs.	

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F 334	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 2 of 8 residents (R23and R366) with federally required written 2012-2013 information regarding the risks and benefits of the current season's influenza vaccine. Findings include: R23 had resided at the facility for over a year and record review revealed R23 had received information/education on the risks and benefits of the influenza vaccine in 10/12. However, further review of the form indicated the information provided was an older version of form 500.97, based on on the 2011/12 season's influenza vaccine. R366 was admitted to the facility on 8/29/12. R366's immunization section of the medical record was reviewed. Review of R366's medical record revealed R366's legal representative had signed form 500.97 on 10/7/12, to indicate the resident was provided written information regarding the risks and benefits of immunization for the 2012/13 seasons influenza vaccine. However, further review of the form indicated the information provided was an older version of form 500.97, which was last revised on 10/9/07, and based on the 2007/06 season's influenza vaccine. On 1/15/13, at 3:20 p.m. the director of nurses (DON) stated a staff member might have used an incorrect form thinking since the years of 2011/2012 were on the form, they had the current year's information. On 1/17/13, at approximately 11:00 a.m. registered nurse (RN)-D verified the	F 334		

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F 334	Continued From page 13 dates of form 500.97 for R23 and R366 to be 2011/2012. The Influenza Prevention-Influenza Vaccinations policy revised 9/13/12, indicated that prior to offering the influenza immunization, facility staff were to document and date when influenza education was provided to family/resident/legal representative/s. The documentation was to be completed on the Inactivated Influenza Vaccine-What You Need to Know Information Sheet form 500.97. A review of the the influenza education forms provided to R23 and R366 revealed the information/education provided to R23 and R366 was provided on form 500.97, but the form was dated prior to the 2012-13 flu season.	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain resident food in a sanitary manner, potentially affecting the majority of residents on those units.	F 371	Walker Methodist Health Center does store, prepare, distribute and serve food under sanitary conditions. Corrective Action: Procedural change will occur to allow bowls and dishes to dry while being stored. Once dry, bowls and dishes may be stacked for future use. Identification of other residents: Measures put in place: In-service for all culinary staff on labeling and dating policies and procedures began on 1/22/13 and will be completed by 2/13/13. Re-education of direct care staff on labeling and dating policies and procedures will be completed by 2/26/2012.	2/26/2013

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F 371	Continued From page 14 On 1/14/13, from approximately 8:25 a.m. to 8:45 a.m. a kitchen tour was conducted with the assistant director of food services. Approximately 100 ready to use bowls were stored wet on two stainless steel carts. On 1/14/13, at 8:30 a.m. an initial tour of the facility revealed opened foods and beverages were unlabeled in unit kitchenettes. The observations were as follows: 1) On unit 7 Gamble, the dietary staff and nursing staff were observed in the process of serving breakfast out of the kitchenette. A large container of applesauce and a container of pears and prunes covered with plastic wrap were observed. The containers were unlabeled and undated when opened. A small refrigerator outside of the kitchenette had a restaurant bag containing two to-go boxes and one opened bottle of cola that were unlabeled or dated. 2) On unit 6 Gamble the kitchenette refrigerator was observed to have a container of prunes covered with plastic that was unlabeled and undated. 3) On unit 5 gamble the kitchenette was observed to have cheese slices wrapped in plastic wrap not completely covering the cheese, causing the edges to dry. Cherries in juice were covered with plastic wrap and were unlabeled and undated. The small refrigerator outside kitchenette had an individual serving size of vanilla pudding. The container top was observed to be open, a large container of applesauce with approximately a quarter left and a half full individual sized cranberry juice were undated and	F 371	Re-education of all culinary staff on the proper storage of dishes to allow for air drying began on 1/22/13 and will be completed by 2/13/13. Monitoring performance: Unit refrigerators will be audited weekly to ensure all food contained is properly stored, labeled and dated. Proper drying procedures will be monitored daily by the Culinary Supervisor or designee. Audit findings will be brought to the Quality Assurance committee for review and recommendations of further actions. Person responsible for plan of correction: Director of Culinary Services or designee.	

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F 371	Continued From page 15 unlabeled. 4) On unit 5 Raines the kitchenette refrigerator had a tray containing several pre-poured glasses of juice. The glasses were not covered, labeled or dated. 5) On unit 4 Gamble the kitchenette refrigerator had a container of prunes covered with plastic wrap which was unlabeled or dated. The small refrigerator outside the kitchenette contained a bagel with cream cheese, meat in a small bag, one sandwich, and a large half full container of applesauce which were unlabeled or dated. 6) On unit 3 Gamble the kitchenette refrigerator was observed to have a carton of half and half opened and undated. One bag of flour and one bag of sugar were observed to be open in the cupboard with the bag folded down. The bags of flour and sugar were undated. 7) On unit 3 Raines the kitchenette freezer was observed to have an opened pint sized container of vanilla ice cream undated or labeled. In the refrigerator a large half full tub of margarine, two and a half sandwiches an open half gallon of milk, and an open carton of half and half which were unlabeled or dated. 8) On 1/17/13, at 8:00 a.m. the resident nourishment refrigerator on units 2 and 3 Gamble were observed to contain opened containers of thickened milk. The containers were undated when opened. In addition, the 3 Gamble refrigerator contained three meat sandwiches which were undated or labeled and two salads which were undated.	F 371		

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F 371	Continued From page 16 On 1/17/13, at 8:15 a.m. the assistant director of food services verified that items in the refrigerator should have been both labeled and dated. In addition, a policy titled Infection Control Culinary Services dated 7/11/12, indicated food was to be labeled and dated to allow for rotation of supplies.	F 371		

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Walker Methodist Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

POC ok
FS 2-20-13

EXIT: 01.17.2013 DC: 02.26.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karley Reeves	Administrator	2/6/13

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 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Walker Methodist Health Center is a 7-story building with a full basement. The building was constructed at 2 different times. The original 5 story building was constructed in 1964 and was determined to be of Type II(222) construction. In 1983, a 7 story addition was constructed to the North that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. This building has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 336 beds and had a census of 312 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect some residents. Findings include: On facility tour between 10:00 AM and 1:00 PM on 01/15/2013, observation revealed that there are smoke detectors located less than 36" away from HVAC diffusers in the gamble dining areas. This deficient practice was verified by the administrator at the time of the inspection.	K 052	All Gamble dining room smoke detectors will be relocated as necessary to a minimum of 36 inches away from HVAC diffusers. Work will be completed on or before 2/26/13 by TYCO Integrated Securities. Maintenance supervisor or designee will monitor future fire alarm installations, repairs and or changes to the current system for compliance.	2/26/2013
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to comply with NFPA 70, The National Electric Code. This deficient practice could affect some residents. Findings include: On facility tour between 10:00 AM and 1:00 PM on 01/15/2013, observation revealed extension cords in use in room L47. This deficient practice was verified by the administrator at the time of the inspection.	K 147	The extension cords in L47 have been removed by maintenance. The facility will be monitored on an ongoing basis for use of extension cords through environmental rounds and life safety audits for compliance.	2/26/2013