DEPARTMENT OF HEALTH AND	HUMAN	SERVICES			CE	NTERS FOR ME	EDICARE & MED	ICAID SERVICES
	MEDIC	CARE/MEDICAL	D CERTIFIC	CATION A	ND TRAN	NSMITTAL		ID: RI93
	PART I	- TO BE COMP	LETED BY T	THE STAT	E SURVE	EY AGENCY		Facility ID: 00995
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245323 2.STATE VENDOR OR MEDICAID NO. (L2) 677088600	 NAME AND ADDRESS OF FACILITY (L3) WALKER REHABILITATION & HEA (L4) 209 BIRCHWOOD AVENUE WEST PC (L5) WALKER, MN 					 TYPE OF ACTION Initial Termination Validation 	 Recertification CHOW Complaint 	
5. EFFECTIVE DATE CHANGE OF OWNERS	HIP	7. PROVIDER/SUI	PLIER CATEGO	RY	02	(L7)	7. On-Site Visit	9. Other
(L9) 02/01/2017		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey After	Complaint
6. DATE OF SURVEY 06/27/201	8 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR ENDI	NG DATE: (L35)
0 Unaccredited1 TJC2 AOA3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPIC	CE	12/31	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	S:				
From (a):		X A. In Complian	nce With		And/Or A	pproved Waivers Of The	e Following Requirements	<u>:</u>
To (b) :			equirements e Based On:		2.	Technical Personnel	6. Scope of S	ervices Limit
						24 Hour RN	7. Medical D	
12.Total Facility Beds 4	0 (L18)	1. A	acceptable POC			7-Day RN (Rural SNF)		
13.Total Certified Beds 4	0 (L17)	B. Not in Con	npliance with Prog	ram	5.	Life Safety Code	9. Beds/Roor	n
		Requirements a	nd/or Applied Wa	ivers:	* Code:	Α	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACIL	ITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
40								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS (IF	APPLICABL	E SHOW LTC CANCE	LLATION DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE	E SURVEY AGENCY A	APPROVAL	Date:
<u> Debra Vincent HFE - NE II</u>		0	07/03/2018	(L19)	Joanne Simon, Enforcement Specialist 07/03/2018			
PART	II - TO BE	COMPLETED	BY HCFA RI	EGIONAL	OFFICE	OR SINGLE ST	ATE AGENCY	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH	CIVIL	21.		cial Solvency (HCFA-257	
_X 1. Facility is Eligible to Participat	e	RIC	GHTS ACT:			 Ownership/Control Both of the Above 	Interest Disclosure Stmt ((HCFA-1513)
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE 23. I	TC AGREEM	ENT 24	I. LTC AGREEM	1ENT	26. TERM	INATION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ	<u>VOLUNTA</u>	<u>RY</u> 00	INVOLU	NTARY
07/01/1986					01-Merger,	Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisf	action W/ Reimburseme	nt 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of I	nvoluntary Termination	OTHER	
2	A. Suspensior	of Admissions:			04-Other Re	eason for Withdrawal	07-Provid	ler Status Change
(L27)			(L44)				00-Active	
	 Rescind Sus 	pension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	RKS		
		01111						
(L	28)			(L31)				
31 RO RECEIPT OF CMS-1539	32	DETERMINATION	F APPROVAL D	ATE				

(L33)

DETERMINATION APPROVAL

05/16/2018

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

STATE AGENCY REMARKS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

A survey was conducted by the Minnesota Department of Health on 3/19/18, through 3/27/18. The survey resulted in an Immediate Jeopardy (IJ) at F689 and F880. The IJ for F689 was removed on 3/27/18, at 12:00 p.m. after verification of a removal plan. The IJ for F880 was removed on 3/27/18, at 12:00 p.m. after verification of an appropriate removal plan.

An extended survey was conducted by the Minnesota Department of Health on 3/23/18 through 3/27/18.

On May 10, 2018 an onsite revisit found this facility to be in continued non-compliance.

Seond onsite revisit on June 27, 2018 found this facility to be in compliance.

ID: RI93



CMS Certification Number (CCN): 245323 July 3, 2018

Mr. Brian Reindl, Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West PO Box 700 Walker, MN 56484

Dear Mr. Reindl:

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

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

Effective June 27, 2018 the above facility is certified for for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

REVISED

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

July 13, 2018

Mr. Brain Reindl, Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West PO Box 700 Walker, MN 56484

RE: Project Number S5323027

Dear Mr. Reindl:

This letter will replace the Notice of Total Amount of Assessment for Nursing Homes dated July 3, 2018. The penalty assessment was not calculated correctly. The total amount due is \$2,343.00. Please submit a check for the remaining fee of 30.00.

On July 13, 2018, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on June 27, 2018, imposed a daily fine in the amount of \$1700.00.

A reinspection was held on June 27, 2018 and it was determined that compliance with the licensing rules was attained. A copy of this revised letter is being delivered electronically.

Therefore, the total amount of the assessment is \$1700.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$643.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$2,343.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Walker Rehabilitation & Healthcare Center July 13, 2018 Page 2

5 6

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Kami Fiske-Downing, Licensing and Certification Program Penalty Assessment Deposit Staff



Electronically delivered

July 2, 2018

Mr. Brian Reindl, Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West Po Box 700 Walker, MN 56484

RE: Project Number S5323027

Dear Mr. Reindl:

On April 17, 2018, we informed you that the following enforcement remedies was being imposed:

• State Monitoring effective April 22, 2018. (42 CFR 488.422)

• Denial of payment for new Medicare and Medicaid admissions effective June 27, 2018. (42 CFR 488.417 (b))

In addition, this Department recommended to the CMS Region V Office the following actions:

• Civil money penalties. (42 CFR 488.430 through 488.444)

Also, on April 17, 2018 you were notified by this department, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 27, 2018.

This was based on the deficiencies cited by this Department for an extended survey completed on March 27, 2018. The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) were required.

On May 10, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 27, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on March 27, 2018.

As a result of the revisit findings, we notified you on May 25, 2018, that the Category 1 remedy of state monitoring would remain in effect.

Also on May 25, 2018 this department recommended to the CMS Region V Office the following actions:

Walker Rehabilitation & Healthcare Center July 2, 2018 Page 2

• Civil money penalties be imposed. (42 CFR 488.430 through 488.444)

• Denial of payment for new Medicare and Medicaid admissions effective June 27, 2018 would remain in effect. (42 CFR 488.417 (b))

On June 27, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 15, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 27, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 27, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalties will remain in effect. (42 CFR 488.430 through 488.444)
- Denial of payment for new Medicare and Medicaid admissions be rescinded effective June 27, 2018. (42 CFR 488.417 (b))

As we notified you in our letter of April 17, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 27, 2018.

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe Health of All Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electonically Delivered

July 3, 2018

Mr. Brian Reindl, Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West PO Box 700 Walker, MN 56484

RE: Project Number S5323027

Dear Mr. Reindl:

On June 27, 2018, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on June 27, 2018, imposed a daily fine in the amount of \$1700.00.

A reinspection was held on June 27, 2018 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$1700.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$643.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$2,313.80 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File
 Shellae Dietrich, Licensing and Certification Program
 Kami Fiske-Downing, Licensing and Certification Program
 Penalty Assessment Deposit Staff

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DEFA		OF.	HEALIN	AND	HUMAN	SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: RI93

		PART I	- TO BE COMP	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00995
1. MEDICARE/MEDICAL	ID PROVIDER NO).	3. NAME AND AL				4. TYPE OF ACTION: <u>7 (</u> L8)
(L1) 245323						ALTHCARE CENTER	1. Initial 2. Recertification
2.STATE VENDOR OR MI	EDICAID NO.		(L4) 209 BIRCH	WOOD AVENU	E WEST P		3. Termination 4. CHOW
(L2) 677088600			(L5) WALKER, N	MN		(L6) 56484	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CH	IANGE OF OWNE	RSHIP	7. PROVIDER/SU	PPLIER CATEGO	RY	<u>02</u> (L7)	
(L9) 02/01/2017			01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	05/10/20	018 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STA	ATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 2 AOA	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CER	TIFICATION		10.THE FACILITY	IS CERTIFIED AS	:		
From (a):			A. In Complia	ance With		And/Or Approved Waivers Of Th	e Following Requirements:
To (b) :				Requirements ice Based On:		2. Technical Personnel	6. Scope of Services Limit
			Compilan	de based on.		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds		40 (L18)	1	Acceptable POC		4. 7-Day RN (Rural SNF	³) 8. Patient Room Size
13.Total Certified Beds		40 (L17)	X B Not in Co	mpliance with Progr	am	5. Life Safety Code	9. Beds/Room
15.10tal Certified Beds		10 (217)		and/or Applied Wai		* Code: B *	(L12)
14. LTC CERTIFIED BED	BREAKDOWN					15. FACILITY MEETS	
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
	40						
(L37)	(L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AG							
	ENCI KEWAKKS	(IF AFFLICABL	E SHOW LIC CANCI	ELLATION DATE)	•		
See Attached Remarks							
17. SURVEYOR SIGNAT	URE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Rebecca Hab	erle, HFE -	NE II		05/25/2018	(L19)	Joanne Simon, Enfo	prcement Specialist 07/02/2018 (L20)
Rebecca Hab	,				. ,		· (L20)
19. DETERMINATION O	PAR		20. COM	BY HCFA RE	GIONAI	Joanne Simon, Enfo OFFICE OR SINGLE ST 21. 1. Statement of Finar	ATE AGENCY ncial Solvency (HCFA-2572)
	PAR F ELIGIBILITY	T II - TO BE	20. COM	BY HCFA RE	GIONAI	Joanne Simon, Enfo OFFICE OR SINGLE ST 21. 1. Statement of Finar	ATE AGENCY acial Solvency (HCFA-2572) 1 Interest Disclosure Stmt (HCFA-1513)
19. DETERMINATION O _X_ 1. Facility i	PAR F ELIGIBILITY	T II - TO BE	20. COM	BY HCFA RE	GIONAI	Joanne Simon, Enfo COFFICE OR SINGLE ST 21. 1. Statement of Finar 2. Ownership/Contro	ATE AGENCY acial Solvency (HCFA-2572) 1 Interest Disclosure Stmt (HCFA-1513)
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19. DETERMINATION O _X_ 1. Facility i	PAR F ELIGIBILITY is Eligible to Partici is not Eligible	T II - TO BE	20. COM 20. COM RI	BY HCFA RE	CIVIL	Joanne Simon, Enfo COFFICE OR SINGLE ST 21. 1. Statement of Finar 2. Ownership/Contro	ATE AGENCY acial Solvency (HCFA-2572) 1 Interest Disclosure Stmt (HCFA-1513)
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19. DETERMINATION O 1. Facility i 2. Facility 22. ORIGINAL DATE	PAR F ELIGIBILITY is Eligible to Partici is not Eligible 2:	T II - TO BE ipate (L21) 3. LTC AGREEM	20. COM 20. COM RI ENT 2	BY HCFA RE MPLIANCE WITH O GHTS ACT: 24. LTC AGREEM	CIVIL ENT	Joanne Simon, Enfo OFFICE OR SINGLE ST 21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION:	ATE AGENCY Acial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30)
19. DETERMINATION O 1. Facility i 2. Facility 22. ORIGINAL DATE OF PARTICIPATION	PAR F ELIGIBILITY is Eligible to Partici is not Eligible 2:	T II - TO BE ipate (L21) 3. LTC AGREEM	20. COM 20. COM RI ENT 2	BY HCFA RE MPLIANCE WITH O GHTS ACT: 24. LTC AGREEM	CIVIL ENT	Joanne Simon, Enfo COFFICE OR SINGLE ST 21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY	(L20) ATE AGENCY Incial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety
19. DETERMINATION O 1. Facility i 2. Facility 22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24)	PAR F ELIGIBILITY is Eligible to Partici is not Eligible 2:	T II - TO BE ipate (L21) 3. LTC AGREEM BEGINNING (L41)	EXAMPLETED 20. COM RI ENT 2 DATE	BY HCFA RE MPLIANCE WITH O GHTS ACT: 24. LTC AGREEM ENDING DATI	CIVIL ENT	Joanne Simon, Enfo COFFICE OR SINGLE ST 21. 1. Statement of Finar 20. 0. Statement of Finar 20. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 01	ATE AGENCY ATE AGENCY Incial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement
19. DETERMINATION O 1. Facility i 2. Facility 22. ORIGINAL DATE OF PARTICIPATION 07/01/1986	PAR F ELIGIBILITY is Eligible to Partici is not Eligible 2:	T II - TO BE ipate (L21) 3. LTC AGREEM BEGINNING (L41) 7. ALTERNATIV	EXAMPLETED 20. COM RI ENT 2 DATE	BY HCFA RE MPLIANCE WITH O GHTS ACT: 24. LTC AGREEM ENDING DATI	CIVIL ENT	Joanne Simon, Enfo OFFICE OR SINGLE ST 21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	(L20) ATE AGENCY Interest AGENCY Interest Disclosure Stmt (HCFA-1513) (L30) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety of Meet Agreement
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19. DETERMINATION O 1. Facility i 2. Facility 22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24) 25. LTC EXTENSION D	PAR F ELIGIBILITY is Eligible to Partici is not Eligible 2: 1 PATE: 27 (L27)	T II - TO BE ipate (L21) 3. LTC AGREEM BEGINNING (L41) 7. ALTERNATIV A. Suspension B. Rescind Sus	COMPLETED 20. CON RI 2	BY HCFA RE MPLIANCE WITH O GHTS ACT: 44. LTC AGREEM ENDING DATH (L25) (L44) (L45)	CIVIL ENT	Joanne Simon, Enfo OFFICE OR SINGLE ST 21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	ATE AGENCY acial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30)
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: RI93 Facility ID: 00995

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

A survey was conducted by the Minnesota Department of Health on 3/19/18, through 3/27/18. The survey resulted in an Immediate Jeopardy (IJ) at F689 and F880. The IJ for F689 was removed on 3/27/18, at 12:00 p.m. after verification of a removal plan. The IJ for F880 was removed on 3/27/18, at 12:00 p.m. after verification of an appropriate removal plan.

An extended survey was conducted by the Minnesota Department of Health on 3/23/18 through 3/27/18.

On May 10, 2018 an onsite revisit found this facility to be in continued non-compliance.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 25, 2018

Mr. Brian Reindl, Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West PO Box 700 Walker, MN 56484

RE: Project Number S5323027

Dear Mr. Reindl:

On April 17, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 22, 2018. (42 CFR 488.422)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective June 27, 2018. (42 CFR 488.417 (b))

Also on April 17, 2018, this department recommended to the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

• Civil money penalty for the deficiencies cited at F607, F686, F688, F689, F745 and F880. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on March 27, 2018. The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On May 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 27, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 27, 2018. The deficiencies not corrected are as follows:

F0677 S/S D Adl Care Provided For Dependent Residents
F0686 S/S D Treatment/svcs To Prevent/heal Pressure Ulcer
F0688 S/S D Increase/prevent Decrease In Rom/mobility
F0758 S/S D Free From Unnec Psychotropic Meds/pm Use
F0810 S/S D Assistive Devices - Eating Equipment/utensils

Walker Rehabilitation & Healthcare Center May 25, 2018 Page 2

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty will be imposed. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective March 27, 2018

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

• Civil money penalty for the deficiencies cited at F677, F686, F688, F758, and F810 effective May 17, 2018. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of April 17, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 27, 2018.

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.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Walker Rehabilitation & Healthcare Center May 25, 2018 Page 3

Email: lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include electronic acknowledgement signature of provider and date.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare

Walker Rehabilitation & Healthcare Center May 25, 2018 Page 4 and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 27, 2018 (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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of

Walker Rehabilitation & Healthcare Center May 25, 2018 Page 5

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

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

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Walker Rehabilitation & Healthcare Center May 25, 2018 Page 6

Feel free to contact me if you have questions.

Sincerely,

35 6

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION (X3) D	<u>D. 0938-039</u> ATE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G CC	DMPLETED
		245323	B. WING _	O	R 5/10/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0/10/2010
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
{E 000}	Initial Comments		{E 000)}	
{F 000}	compliance with Cl Preparedness Req		{F 000)}	
	completed on 5/9/1	tification revisit (PCR) was l8, and 5/10/18, and found to ed all the citations issued on /27/18.			
{F 677} SS=D	signature is not rec page of the CMS-2 submission of the I verification of comp	for Dependent Residents	{F 67]	7}	6/15/18
	out activities of dai services to maintai personal and oral h	sident who is unable to carry ly living receives the necessary n good nutrition, grooming, and nygiene; NT is not met as evidenced			
	Based on observa review, the facility f assistance with inc	tion, interview and document failed to provide timely ontinence cares for 1 of 3 to was totally dependent on ce cares.		F677 SS=D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that	
	Findings include:			one was cited correctly. This Plan of Correction is submitted to meet	
	3/9/18, identified R	nimum Data Set (MDS) dated 23 with severe cognitive agnoses including dementia,		requirements established by state and federal law. 1. It is the policy of this facility to provid	e

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE
Electronically Signed

PRINTED: 06/25/2018

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.

DEDARTMENT OF LICALTU AND LUMANN SERVICES

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED
						२
		245323	B. WING		05/	10/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	K 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 677}	Continued From pa	ae 1	{F 677	7}		
	history of stroke an The MDS indicated assistance with all a indicated he was to R23's annual MDS R23 as being totally bladder. R23's Urinary Incor identified R23 as be bowel and bladder to check and change every two hours. R23's care plan pro- staff to check and change every two hours. R23's care plan pro- staff to check and change every two hours. R23's care plan pro- staff to check and change every two hours. During continuous of 4:20 p.m. to 8:20 p receive assistance -At 4:20 p.m. nursin were observed to tr wheelchair via a ful -At 5:05 p.m. regist R23 to the dining ro -At 5:22 p.m. NA-A meal. -At 6:19 p.m. R23 v remained in his roo until 7:40 pm. -At 7:40 p.m. NA-G facility at 6:00 p.m.	d aphasia (inability to speak). R23 required extensive activities of daily living and stally incontinent of bladder. dated 10/13/17, also identified y incontinent of bowel and htinence CAA dated 10/9/17, eing totally incontinent of and directed the staff to assist ge R23's incontinence brief ovided on 5/10/18, directed change R23's incontinence rs. observations on 5/9/18, from .m. R23 was not observed to with incontinence cares. ng assistant (NA)-C and NA-A 'ansfer R23 from bed to a I body mechanical lift. ered nurse (RN-B) wheeled	{F 0//	consistent quality care to residen needing assistance with their ADI Some of the ways this is done is gathering data through assessme ensure all residents needing assi with ADL □s such as ambulating, grooming, dressing, and toileting/incontinent care are iden assisted appropriately. In this ca the survey determined R23 did na adequate incontinent care and wa identified as completely depende staff for incontinent care the staff advised to ensure residents are of timely and cares done according plan and care sheets. Since surv have been educated on important providing incontinent care to reside based on their care plan and follot their care sheets. R23 remains o 2-hour check and change and repositioning at this time. 2. Because all residents have c changing needs all are potentially by the cited deficiency, on 6/1/20 regional nurse reviewed resident assistance with incontinence care ensured plan of care is correct ba needs. MDS nurse will review ea quarter if resident goals being me ensure staff follow through with c current review was completed of residents with similar incontinent Policy and procedure on incontin	Los. by ents to stance tified and se, after ot receive as nt on were changed to care ey, staff ce of dents owing n every onstantly v affected 18, the s needing e and ased on ch et and ares. A all needs.	
	get to him.	NA-G stated she would try to continued to be seated in the		 has been reviewed. No other resilvere affected. 3. To enhance currently complian operations and under the direction regional nurse, on 6/6/2018 all nurse. 	ant n of the	

Facility ID: 00995

If continuation sheet Page 2 of 25

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDIN	G		R
		245323	B. WING		05/10	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
{F 677}	Continued From pa	ige 2	{F 677	7}		
	-At 8:15 p.m. NA-A	stated she could not assist		staff will receive in-service	training	
		sy answering lights for other		incontinence care, dignity		
	residents. NA-A co assisted with incon	nfirmed R23 had not yet been		following care sheets. The emphasize the importance		
		rector of nursing (DON) and		time between incontinent		
		or of Clinical Services		reviewing that poor inconti		
		nd connected him to a full body		lead to skin breakdown. R	eviewed staff	
		-A entered the room and		expectations regarding fol		
		nal Director of Clinical Services n the wheelchair to the bed.		sheets and performing AD to resident cares and staff		
		completed perineal cares.		job performance.	expectations of	
		to be incontinent of urine.		4. Effective 6/4/2018, a		
		3 had last been assisted with		quality-assurance program		
		at 4:20 p.m. 4 hours and 6		implemented under the su		
	minutes earlier.			regional nurse and MDS to residents needing assistar		
	On 5/10/18. at 11:3	0 a.m. the DON stated R23		The DON or designee will		
		stance with incontinence cares		residents daily for 5 days (
	every two hours as	directed by the plan of care.		evenings) to ensure all res		
	The Telletine weller			incontinent care are receiv	•	
		and procedure dated 4/2/18, assist residents to the toilet in		appropriately. After the on monitor 5 residents week		
		accordance to their		and then 3 residents week		
		of care. The policy indicated		All residents will be review		
	that if a resident wa	as unable to physically tolerate		quarterly or annual to ensu		
		et, the staff were to adhere to		significant change. Any de	ficiencies will	
		e program based on a bowel		be corrected on the spot, a		
	and bladder assess	sment.		of the quality-assurance cl documented and submitte		
				quality-assurance commit		
				further review or corrective		
				5. DON or designee will	be responsible	
				for this POC. 6. Completion date 6/15/	18	
{F 686} SS=D	Treatment/Svcs to CFR(s): 483.25(b)(Prevent/Heal Pressure Ulcer 1)(i)(ii)	{F 686	-	10	6/15/18

Facility ID: 00995

If continuation sheet Page 3 of 25

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	Сом	E SURVEY PLETED
		245323	B. WING _		R 05/10/2018	
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
{F 686}	Continued From pa	age 3	{F 686	5}		
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that if (ii) A resident with p necessary treatment with professional st promote healing, pu new ulcers from de This REQUIREMENT by: Based on observation review, the facility f repositioning assist plan for 2 of 3 resid identified at risk for staff assistance for Findings Include: R5's quarterly Minin assessment dated moderate cognitive including Parkinson depression. The M assistance of two s living including bed MDS also identified of pressure ulcers. R5's Pressure Ulce (CAA) dated 9/6/17 development of pre-	brehensive assessment of a y must ensure that- yes care, consistent with ards of practice, to prevent d does not develop pressure ndividual's clinical condition they were unavoidable; and pressure ulcers receives nt and services, consistent tandards of practice, to revent infection and prevent eveloping. NT is not met as evidenced tion, interview and document failed to provide timely tance as directed by the care dents (R5, R23) reviewed who pressure ulcers and required		 F686 SS=D This Plan of Correction constitute written allegation of compliance of deficiencies cited. However, sub of this Plan of Correction is not a admission that a deficiency exist one was cited correctly. This Place Correction is submitted to meet requirements established by state federal law. It is the policy of the facility to treatment and services to prever pressure ulcers. One of the man that this has been achieved for FR23 was to have tissue tolerance redone and identify skin conditionextent of redness. R5 and R23 wrepositioned q2h as suggested as intervention on their care plan to further breakdown. After survey the residents had not been repositioned redome and identify has noted they be scored high for potential in skin i due to their incontinence and ability for potential in skin i due to their incontinence and ability of the set of the state of the	For the mission n s or that an of e and o provide at y ways to and e test n and vere not s prevent noted that sitioned oth ntegrity	

Facility ID: 00995

If continuation sheet Page 4 of 25

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
		245323	B. WING			R	
	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		10/2018	
		HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WES WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
{F 686}	•	-	{F 686	-			
	weekly skin assess R5's skin while ass	ed staff were to complete ments and were to monitor isting with personal cares. (a tool utilized to predict		and reposition independ pressure reduction cush reassessed skin and on q2h, and care plan upda been assessed to have	ion, mattress, turn and repo ated. R23 has		
	pressure ulcer deve	elopment) dated 5/8/18, risk for development of		integrity. Skin check con repositioning and tissue reassessed; on turn and sheets and care plans u	npleted, on 2-hour tolerance I repo q2h. Care		
	5/9/18, indicated R area over boney pr did not identify whic skin change/suscep	nce Observation form dated 5 displayed a "slightly red" ominences. However, the form ch boney prominences had otibility to pressure nor any for the staff to implement.		2. Because all resident potential to alteration in to illness or have potent breakdown all are poten the cited deficiency, wou documentation has been interventions for prevent	ts are at risk for skin integrity due ial for skin tially affected by und n reviewed,		
	R5's care plan prov interventions for sta repositioning at leas			and documented clearly Weekly skin audits are of staff update nurse mana new areas noted immed	on care sheets. completed, and agement on any		
	was observed to tra wheelchair via a ful	p.m. nursing assistant (NA)-C ansfer R5 from bed into a I body mechanical lift. as wheeled into the dining		reporting of any bruises, breakdown or rashes. A with needing turning and were assessed for week with appropriate interver	Il current resident d repositioning dy changes along		
	evening meal. -At 5:40 p.m. R5 wa room and to his roo			Implementation of those reviewed on skin checks regional nurse if residen otherwise. Staff educate	s. Staff to alert t refuses ed on importance		
	room, seated in the -At 7:05 p.m. NA-G to assist R5 with ev	entered R5's room and began		of offloading, repositioni updated, care sheets up residents were affected. prevention of skin break reviewed.	dated. No other The policy on		
	observed equipped cushion. R5's butto	R5's wheelchair was with a pressure redistribution cks were pink and the coccyx a small crevasse with thin,		3. To enhance currentl operations and under the regional nurse, on 6/6/20 receive in-service trainin skin and pressure areas	e direction of the 018 all staff will ig for monitoring		

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If continuation sheet Page 5 of 25

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				R		
		245323			05/*	10/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
{F 686}	last time R5 had be NA-G stated she ha p.m. and had not re R5 had not received for 2 hours and 48 n On 5/10/18, at 9:00 transfer R5 from the body mechanical lift -At 10:55 a.m. the of stated R5 was to re repositiong every tw care plan. R23 did not receive repositiong for great evening of 5/9/18. R23's quarterly MD had severe cognitive which included dem aphasia (inability to R23 required extent mobility and transfe development of pre MDS dated 10/13/1 totally dependent up transfers and at risk pressure ulcers.	stated she was unaware of the een assisted with repositiong. ad arrived at the facilty at 6:00 eceived any type of shift report. d assistance with repositioning minutes. a.m. NA-F was observed to e wheelchair into bed via a full	{F 686		ng to ntegrity. tance ective as g to ortance skin, n of n of the ents on nsure rector surance owing esidents ing and 5 y x 2 orrected monthly ing for	

Facility ID: 00995

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		AND HUMAN SERVICES				FORM	06/25/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245323	B. WING	. <u></u>			२ 10/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 686}	Sore Risk dated 5/8 moderate risk for th ulcers. The Tissue Toleran 3/9/18, indicated R2 areas after two hou R23's care plan pro staff to assist with r During continuous of 4:20 p.m. to 8:20 p. receive assistance -At 4:20 p.m. NA-C transfer R23 from b body mechanical lif -At 5:05 p.m. regist R23 to the dining ro -At 5:22 p.m. NA-A meal. -At 6:19 p.m. R23 w -At 6:30 p.m. until 7 room, seated in the -At 7:40 p.m. NA-G facility at 6:00 p.m. of report when she not know when R23 NA-G stated she wo -At 8:15 p.m. NA-A R23 as she was bu residents. NA-A sta assisted with repos -At 8:20 p.m. the D0 of Clinical Services with repositiong by	2/18, identified R23 at the development of pressure ce Observation Tool dated 23 did not develop reddened 23 did not 5/10/18, directed 24 epositioning every two hours. 25 observations on 5/9/18, from 27 and NA-A were observed to 28 observed to 29 observed to a wheelchair via a full 29 observed to a wheelchair via a full 20 observed and NA-A were observed to 20 observed to a wheelchair via a full 20 observed to a wheelchair via a full 20 observed and NA-A were observed to 20 observed to a wheelchair via a full 20 observed to a wheelchair via a full 20 observed and NA-A were observed to 20 observed to a wheelchair via a full 20 observed and not received any type 20 observed at the facility and did 20 had last been repositioned. 20 ould try to get to him. 20 observed to a wheelchair via a full 20 observed to a stated she could not assist 20 observed to a stated she could not assist 20 observed to a stated she and not yet been	{F 6	86}			

If continuation sheet Page 7 of 25

		AND HUMAN SERVICES				FORM	06/25/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245323	B. WING				R 10/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX VALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 686}	director stated she out of the chair with any type of reposition into the chair. -At 8:25 p.m. the Du approached R23 in to a full body mechar room and assisted Clinical Services to wheelchair to the bu- equipped with a pre R23's buttocks were -At 8:26 p.m. NA-A assisted with repos 6 minutes earlier. On 5/10/18, at 11:3 was to receive assist two hours as directed DON stated when se clinical services have the mechanical lift se for only 10-30 seco order for full tissue the resident would I prominences for a re DON confirmed R2 for a full minute. Superior Healthcare Region policy and p Risk Assessment e following: -pressure ulcers are resident remained i extended period of pressure or decreas	and the DON had lifted him of the lift but did not complete oning, rather R23 back down ON and regional director his room and connected him anical lift. NA-A entered the the Regional Director of transfer R23 from the ed. R23's wheelchair was assure redistribution cushion. e pink and intact. confirmed R23 had last been itiong at 4:20 p.m. 4 hours and 0 a.m. the DON stated R23 stance with repositiong every ed by the plan of care. The she and the regional director of d repositioned R23 by lifting sling, R23 was out of the chair nds. The DON confirmed in perfusion to be accomplished, have to be off of the bony minimum of one minute. The 3 had not been out of the chair ffective 12/23/17, indicated the e usually formed when a n the same position for an time causing increased	{F 6	86}			

Facility ID: 00995

If continuation sheet Page 8 of 25

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED R
		245323	B. WING			05	/10/2018
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			BIRCHWOOD AVENUE WEST PO BO ALKER, MN 56484	DX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
{F 686}	Continued From pa	age 8	{F 6	86}			
	infected	n become larger, painful, and					
	continual pressure, substances on the soap, discharge), d	e often made worse by heat, moisture, irritating resident's skin (feces, urine, lecline in nutrition, and					
	resident's physical -pressure ulcers ar the resident	cute illness or decline in the and/or mental condition e a serious skin condition for					
	the resident's skin care program for a irritation or breakdo -Skin would be ass	essed for the presence of e ulcers on a weekly basis or					
-	Region, Reposition reviewed 4/2/18, in procedure was to p evaluation of reside	hcare Management Minnesota ing policy and procedure dicated the purpose of the provide guideline for the ent repositioning needs, to aid					
	for repositioning, to chair bound resider breakdown, promo pressure relief for r indicated reposition who was immobile repositioning. A rep defined as a specifi organized, planned	of an individualized care plan promote comfort for all bed or nts and to prevent skin te circulation and provide esidents. The policy also ning was critical for a resident or dependent on staff for positioning program was ic approach that was d, documented, monitored and					
{F 688}	evaluated. Increase/Prevent D	ecrease in ROM/Mobility	{F 6	88}			6/15/18

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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		(X3) DATE	
	IDENTIFICATION NUMBER:				PLETED
				F	र
	245323	B. WING _		05/1	0/2018
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIO DATE
§483.25(c)(1) The f resident who enters range of motion doe range of motion unl condition demonstra of motion is unavoid §483.25(c)(2) A res motion receives app services to increase prevent further decr §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract reduction in mobility This REQUIREMEN by: Based on observat review, the facility fa range of motion (RC residents (R23) obs without the assess ROM program in or maintain current RC facility failed to follo related to the applic resident (R5) who w occupational therap Findings include: R23's quarterly Min 3/9/18, indicated R2	acility must ensure that a acility must ensure that a the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range dable; and ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion. ident with limited mobility e services, equipment, and ain or improve mobility with icable independence unless a / is demonstrably unavoidable. NT is not met as evidenced ion, interview and document ailed to assess the need for DM) services for 1 of 3 served with limitations in ROM nent and development of a der to prevent a decline or DM abilities. In addition, the w the therapist's direction eation of splints for 1 of 1 vas currently receiving by.	{F 688	F688 SS=D This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, subm of this Plan of Correction is not ar admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. It is the policy of the facility to resident do not have decline in R0 unless anticipated by clinical cono R23 had not been evaluated for F decline and R5 was having chang splinting due to contractures. After	or the nission or that of and ensure DM lition. COM les in his r survey	
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER REHABILITATION & SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa §483.25(c)(1) The f resident who enters range of motion doe range of motion doe range of motion unl condition demonstra of motion is unavoid §483.25(c)(2) A res motion receives app services to increase prevent further deci §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract reduction in mobility This REQUIREMEN by: Based on observat review, the facility fa range of motion (RC residents (R23) obs without the assess ROM program in or maintain current RC facility failed to follo related to the applic resident (R5) who w occupational therap	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245323 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the need for range of motion (ROM) services for 1 of 3 residents (R23) observed with limitations in ROM without the assessment and development of a ROM program in order to prevent a decline or maintain current ROM abilities. In addition, the facility failed to follow the therapist's direction related to the application of splints for 1 of 1 resident (R5) who was currently receiving occupational therapy. Findings include: R23's quarterly Minimum Data Set (MDS) dated	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 245323 B. WING	OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLIER 245323 STREET ADDRESS, CITY, STATE, ZIP CODE REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTIVE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) PRE PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) PRE PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) PRE PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) PRE PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) PRE PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) PRE PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION NUML CROSS-REFERENCED TO THE APPRO DEFICIENCY MUST BE PLAN OF CORRECTIVE SA 83.25(C)(2) A resident with limited range of motion receives appropriate treatment and assistance to maintain or improve mobility with the maximum practicable independence unless a re	OF DEFICIENCIES F CORRECTION (X1) PROVIDERSUPPLIER/CLA DENTIFICATION NUMBER: (X2) MULTPLE CONSTRUCTION (X3) DATE A BUILDING PROVIDER OR SUPPLIER 245323 B WING 05/7 PREHABILITATION & HEALTHCARE CENTER 29 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 29 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES (EQC) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREVENT TAG PROVIDER SOLUTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Continued From page 9 \$483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion does not experience reduction in range of motion does not experience reduction in range of motion locenstrate stat a reduction in range of motion receives appropriate treatment and assistance to maintain or improve mobility with the meaximum practicable independence unless a reduction in mobility is demonstrately tunavoidable. This REQUIREMENT is not met as evidenced by: F688 SS=D Based on observation, interview and document review, the facility failed to assess the need for range of motion (ROM) services for 1 of 3 resident (R23) observed with limitations in ROM without the assessment and development of a ROM program in order to prevent a decline or maintain current ROM abilities. In addition, the facility failed to follow the therapist's direction related to the application of splints for 1 of 1 resident (R5) who was currently receiving occupational therapy. F188 AS=D Findings include: R23's quarterly Minimu

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	OF DEFICIENCIES	& MEDICAID SERVICES			E CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			ECONSTRUCTION		
			A. BUILDII	NG _			र
		245323	B. WING				、 10/2018
	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	05/	10/2010
					09 BIRCHWOOD AVENUE WEST PO BOX 7	700	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
{F 688}	Continued From pa	age 10	{F 68	ເຊເ			
[]	· ·	I MDS dated 10/13/17,	1 00	NO7	adaptive equipment but no plan in	nlace	
		ired total staff assistance for			and not evaluated by therapy. R5 w		
	all activities of daily				wearing splints that were not his no		
		3.			for him so they were removed and		
	R23's care plan pro	ovided on 5/10/18, directed the			being assessed OT was to use pillo	ows	
		al therapy (PT) and			and wash cloths. Resident was able	e to	
		by (OT)evaluate and treat R23			move hands better and shoulders		
		physician. The care plan also			loosened up although he is neurolo		
		report signs and symptoms of			so as a rule its natural for arms to o		
		actures forming or worsening. not direct the staff to assist R23			chest which appear more contracte		
	with ROM exercise				When resident reminded to put arn down did. Since not everyone was		
		3.			same page OT was unhappy with		
	R23's Therapist Pre	ogress and Discharge			discontinuation however had not no	oticed	
		13/17, indicated R23 had lower			that resident splints were not his pe		
		s in ROM. The physical			name so did reinitiate and did orde		
		nursing staff was to provide			hand splints fitted to him and elbow	/	
		nual stretches including			splints. OTA and regional at time		
		s. The frequency of the			determined resident had more spas		
	exercises was not i	indicated.			than tone and forcing his elbows op		
	D22's Therenist Dr	areas and Discharge			was not helpful as wouldn t fix the		
		ogress and Discharge 4/17, indicated R23 had			position however when state noted note saying it was helpful order cha		
		the upper extremities. The			back. R23 had screen for PT. Note		
		pist indicated R23 was to			limitations to right side and mild to		
		cises however, the frequency			being assessed for adaptive eating		
	of the services was				device. Care sheets and care plans		
					updated.		
		on and Plan of Treatment dated			2. Because all residents have pot	ential	
		R23 had been evaluated by OT			for decline or improvement all are		
		nce devices, but did not include			potentially affected by the cited def		
	restorative program	aluation or directions for a			decline in ROM triggers have been documentation has been reviewed.		
	residiative program	1.			interventions for prevention are in p		
	Review of the facili	ty's Restorative nursing			and documented clearly on care pla		
		not include a restorative			Passive ROM to be completed with		
	nursing program fo				in morning and at night on staff who		
	51 5				ordered by therapy based on scree		
	Review of R23's el	ectronic medication record did			from last survey. ROM orders will b	e clear	

Facility ID: 00995

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. (X3) DATI	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
						R
		245323	B. WING		05/	10/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BC WALKER, MN 56484	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
{F 688}	Continued From pa	ge 11	{F 688	3}		
	not direct the staff t	-	,	with which exercises and for how	v long.	
				Staff update DON or MDS nurse	on any	
		p.m. R23 was observed to be		new declines. All current resider		
		e wheelchair to the bed via a all lift with the assistance of		new baseline and the charting s		
	2	NA)-B and NA-C. R23's shirt		nursing aids indicates if staff not decline in ROM. Therapy to eval		
		served to be saturated with		resident triggering for decline in		
		IA's changed his clothing.		Implementation of those interve		
		staff with his right hand and		reviewed in IDT. Staff to alert D		
		his right leg. While changing		resident refuses otherwise. No		
		oved R23's left leg which		residents were affected. The pol	icy on	
		ons in ROM. NA-C assisted		ROM has been updated.	ont	
		shirt in which R23 was noted the right arm, however, the		 To enhance currently compl operations and under the region 		
		proximately 4-5 inches with		on 6/6/2018 all staff will receive		
		the left shoulder noted.		training on ROM and monitoring		
				The training emphasizes the imp		
		0 a.m. the director of nursing		of following all interventions for e		
		had been screened by therapy		prevention of contractures. Educ		
		wever, R23 had not been by list. Upon review of the OT		done on importance of compreh assessment of ADL s, contract		
		17/18, the DON confirmed		implementation of appropriate	ares and	
		had not been evaluated and		interventions.		
	should have been.			4. Effective 6/4/2018, a		
				quality-assurance program was		
	On 5/10/18, at 1:15			implemented under the supervis		
		by assistant (COTA)-A stated		therapy, nursing and MDS to mo		
		uated for his adaptive t meals, however, R23 was		residents for changes in ROM, F exercises and splinting. The dir		
	not evaluated by O			nurses or designated quality-ass		
				representative will perform the fe		
	R5's quarterly MDS	dated 1/10/18, indicated R5		systematic changes: audit splint		
		itive impairment and		ROM 4 residents weekly x4 wee		
		cluded Parkinson's disease,		residents weekly x 2 months. Ar		
		epression. The MDS indicated		deficiencies will be corrected on		
		ssistance of two staff for bed		and the findings of the quality-as checks will be documented and		
		and all activities of daily living, nctional limitation in range of		at the monthly quality-assurance		
		r and lower extremities. R5's		committee meeting for further re		

Facility ID: 00995

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	CS FOR MEDICARE	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLI T	IPLE CONSTRUCTION		<u>0938-039</u> E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	· /	NG		E SURVEY IPLETED	
						R	
		245323	B. WING _		•	10/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
WALKER	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PC WALKER, MN 56484	3OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
{F 688}	Continued From page 12 admission MDS dated 9/1/17, indicated R5 was dependent upon staff for all activities of daily living and had bilateral functional limitation in ROM of the upper and lower extremities. R5's Activities of Daily Living Care Area		{F 68	8} corrective action. 5. DON will be responsible	for this POC		
	Assessment (CAA) required total staff a living related to enc damage or malfunc	dated 9/6/17, indicated R5 assistance all activities of daily ephalopathy (brain disease, stion), spinal fusion and A indicated R5 was					
	of Treatment dated had bilateral arm co treated by OT for th implementation of in contractures. The i indicated R5 was to and a resting pan-n splints for greater th and symptoms of re pain. The long term	Therapy Evaluation and Plan 4/8/17- 5/7/18, indicated R5 ontractures and was being be evaluation and interventions to minimize arm identified short term goal o utilize a resting hand splint nitt splint and elbow extension han eight hours without signs edness, swelling, discomfort or in goal was to ensure R5 was lints without redness or					
	Notes revealed the - 4/11/18, PROM (p completed, applied - 4/12/18, PROM to applied.	Therapy Treatment Encounter following information: passive range of motion) braces to elbows and hands. pupper extremities and splints					
	expressed discomfe - 4/17/18, PROM to splints applied.	o upper extremities patient ort with stretches. o the upper extremities and o upper extremities and splints					

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		AND HUMAN SERVICES				FORM	1 APPROVED
	RS FOR MEDICARE OF DEFICIENCIES		(V2) MU	тір			. 0938-0391 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					MPLETED
			AND SERVICES FO AID SERVICES OMB 1 CATION NUMBER: (22) MULTIPLE CONSTRUCTION (23) 245323 B. WING (23) BIRCHWOOD AVENUE WEST PO BOX 700 ARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 ARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 MALKER, MN 56484 DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION VECEDED BY FULL PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCED TO THE APPROPRIATE DEFICIENCY) Vectoring staff of splints. (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Vectoring staff of splints. (F 688) FG 688) ress, applied elbow An unusing staff of splints. FG 688) ress, application. Dication. Dication. Dication. polication. Silication. Silication. Silication. olication. Silication. Silication. Silication. olication. Silication. Silication. Silication. olication. Silication. Silication. Silicati			R	
		245323	B. WING	-		05	/10/2018
NAME OF F	PROVIDER OR SUPPLIER					700	
WALKER	REHABILITATION &	HEALTHCARE CENTER				700	
(X4) ID		TEMENT OF DEFICIENCIES					(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					COMPLETION DATE
					DEFICIENCY)		
 {F 688} Continued From page 13 adjusted for proper fit. 4/23/18, PROM to contractures, applied elbow splints. 4/25/28, PROM and educated nursing staff present for proper application of splints. 4/26/18, PROM, educated staff on prolonged stretches and splint application. 							
{ [-	{⊢ 6	88;	}		
	splints.						
		nd splint application.					
	- 5/1/18, PROM and						
	NA's on proper place						
	- 5/7/18, PROM with	h stretches, communicated					
		ation of splints and prolonged					
	stretching for R5.	d application of elbow and					
	hand splints.						
		gress note dated 4/30/18, ad removed R5's right braces					
	due to the knuckles						
		vided on 5/10/18, included					
		g pillows to position arms in					
	chair and staff to re	mind to extend throughout the					
	day. Washcloths in	n hands at night."					
	On 5/9/18. at 1:00 r	o.m. R5 was observed seated					
	in a wheelchair in h	is room. R5's arms were					
		ted at the elbows, wrists,					
	hands and shoulder type of braces.	rs. R5 was not utilizing any					
		as observed in bed, no splints					
	were observed.	•					
		as transferred from bed to					
		I body mechanical lift. NA-C ansfer. Once in the chair,					
		erved to encourage R5 to do					
		es and pillows were not placed.					

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		AND HUMAN SERVICES				FORM	06/25/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245323	B. WING	i			२ 10/2018
NAME OF I	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 688}	 At 7:10 p.m. NA-G the wheelchair to be cares. NA-G did no pillows or washcloth stated R5 was to ut was not able to loca in R5's room. NA-G any new directions - At 7:53 p.m. licens stated R5 was to ut Upon review of the LPN-C reported the recorded on the ele however, they had b she had not receive related to R5's cont shift report. On 5/10/18, at 7:05 in a wheelchair in h to be contracted, no wer observed to be - At 7:08 a.m. NA-B informed of new pill NA-B stated the Re Services had explai for R5's comfort but how they were to be not have washcloth assisted him out of complete PROM for to be extend to a 90 the shoulder was al 2-3 inches, the wris and the fingers of th be opened more that held the right hand elbow moved to about the shoulder was about to about the shoulder was about the shoulder was	G assisted to transfer R5 from ed and complete bedtime of apply any type of brace, hs into R5 hands. NA-G tilize splints, however, NA-G ate the splints as they were not G stated she had not received for R5's care. sed practical nurse (LPN)-C tilize hand splints at bedtime. electronic treatment record, e splints had previously been ectronic treatment record, been removed. LPN-C stated ed any type of new directions tractures or splint use during G a.m. R5 was observed seated is room. R5's arms continued o pillows, washcloths or splints	{F 6	88}			

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		AND HUMAN SERVICES				FORM	06/25/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245323	B. WING				२ 10/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 688}	 When NA-B had coplaced a pillow undaway from his body At 8:15 a.m. R5 widining room. R5 diaplace at the time of Review of R5's clinic comprehensive assidiscontinuation of the pillows and widiscontinuation of the pillows and widiscontinued the spidirected the staff to The DON stated the dinformed of the character plan. 1:10 p.m. R5 was wheelchair in his roclinical services corpillows in place as of then placed pillows At 1:20 p.m. COT/COTA and the region had reviewed R5's discontinuation. Contacted the OT and discontinuation. Contacted the ot and discontinuation of Fwas "unhappy" with not initiated the character plan. 	ompleted the exercises, she er R5's elbows to extend them <i>x</i> . vas observed being fed in the d not have a pillow or splints in the meal. ical record lacked a sessment of the he splints and the application vashcloths. DON stated the therapist had blints on 5/9/18, and had o use pillows and washcloths. e staff were to have been ange via shift report and the observed seated in his bom. The regional director of nfirmed R5 did not have directed. the regional director	{F 6	88}			

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		AND HUMAN SERVICES			FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
		245323	B. WING			R
NAME OF I	PROVIDER OR SUPPLIER	243323	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	05/	10/2018
		HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX	700	
				WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 688}	Continued From pa	ige 16	{F 68	8}		
	OT-A was not availa survey.	able for interview during the				
	4/2/18, directed the joints and muscles. staff to verify a phys received and if then to contact the atten order, as needed. In	on Exercises policy dated e staff to exercise the residents' The policy also directed the sician order for ROM had been re was no order, the staff were ding physician to obtain an n addition the staff were he following in the resident				
{F 758} SS=D	- The type of ROM - Whether the exerce - How long the exerce - If and how the ress procedures or any of ability to participate - Any problems or of residents related to - If the resident refut why along with inter Free from Unnec Particle CFR(s): 483.45(c)(3) §483.45(c)(3) A psy affects brain activitie	berson providing the exercise. exercises. cise was active of passive. rcise was conducted. sident participated in the changes in the resident's complaint made by the the procedure. used the treatment and reason rventions taken. sychotropic Meds/PRN Use 3)(e)(1)-(5)	{F 75	8}		6/15/18
	but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant;	o, drugs in the following				

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
						F F	२
		245323	B. WING			05/1	10/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		DATE
					DEFICIENCY)		
([750]		47	(= ==				
{F 758}	•	•	{F 75	v8}			
	(iii) Anti-anxiety; and (iv) Hypnotic	a	re assessment of a				
		ehensive assessment of a must ensure that					
	\$483.45(e)(1) Resid	dents who have not used					
	psychotropic drugs	are not given these drugs					
		ion is necessary to treat a					
	in the clinical record	s diagnosed and documented d;					
		dents who use psychotropic					
		ual dose reductions, and tions, unless clinically					
		an effort to discontinue these					
	drugs;						
	\$492 45(a)(2) Daai	dente de net receive					
		dents do not receive pursuant to a PRN order					
	unless that medicat	tion is necessary to treat a					
	.	condition that is documented					
	in the clinical record	1; and					
		orders for psychotropic drugs					
		ys. Except as provided in					
		e attending physician or oner believes that it is					
		PRN order to be extended					
		or she should document their					
		dent's medical record and					
	Indicate the duration	n for the PRN order.					
	§483.45(e)(5) PRN	orders for anti-psychotic					
		14 days and cannot be					
		e attending physician or oner evaluates the resident for					
		s of that medication.					

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
		245323	B. WING			2
	PROVIDER OR SUPPLIER	243323	<u> B. Millo –</u>	STREET ADDRESS, CITY, STATE, ZIP CO		10/2018
	NOVIDER ON OUT FIER			209 BIRCHWOOD AVENUE WEST PO		
WALKER	R REHABILITATION &	HEALTHCARE CENTER		WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
{F 758}	Continued From pa	nge 18	{F 758	31		
[1 100]	This REQUIREME	NT is not met as evidenced	1 7 30	۲c		
	review, the facility f (PRN) antianxiety r	tion, interview and document ailed to ensure an as needed nedication had a documented		F758 SS=D		
	exceeding 14 days received PRN antia justification for its u addition, the facility pattern for 1 of 1 re received a daily hyp	tinued use of the medication for 1 of 1 resident (R3) who anxiety medication without the use longer than 14 days. In failed to monitor the sleep esident (R13) reviewed who ponotic without adequate re medication efficacy and as sician.		This Plan of Correction cons written allegation of complian deficiencies cited. However, of this Plan of Correction is r admission that a deficiency of one was cited correctly. This Correction is submitted to m requirements established by federal law.	nce for the submission not an exists or that s Plan of eet state and	
	Findings include:			 It is the policy of the faci guidelines regarding use of I psychotropic medications. F 	PŔN	
		ted 5/10/18, included failure and chronic respiratory		facility failed to ensure these who received their prn antiar medications had rationale fo the medication longer than the	e residents nxiety r utilization of	
	(PMR) dated 4/19/ related to the Center Services (CMS) reg clear risk vs. benefit to be in place to wa PRN psychotropic r and unfortunately h these regulation. Th indicated to the phy providing clinical do need and consider the patient's quality	armacist's Medication Review 18, identified an irregularity er for Medicare/Medicaid gulations which required a it analysis and documentation arrant the continuation of a medication beyond 14 days ospice orders are included in he recommendation further ysician, to please consider ocumentation of continued how you feel it could improve of live. Could consider tion as was scheduled in the		regulation. R13 was on hypr not have sleep study done to effective. R3 recommendation for follow up documentation. have sleep study completed medications have been revise consultant and discussed at The framework has been se adequate follow up with dose proper diagnoses, sleep mon behaviors put in place on TA compliance with the 14-day MAR□s and TAR□s updated plans updated.	o determine if on sent to MD R13 did . All ewed with QAPI in April. t to ensure e reductions, nitoring, target .R and overall regulation.	
	past. The physiciar rejected the recom current dosing and	r this hospice patient and		 Because many residents for PRN psychotropics, man potentially affected by the cit staff were reminded to ensure 	y are ed deficiency,	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245323		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						२	
		B. WING		05/*	05/10/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WES WALKER, MN 56484	T PO BOX 700		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	SHOULD BE COMPLETION	
{F 758}	Continued From pa	age 19	{F 75	8}			
	scheduling a benzodiazepine was not appropriate. R3's Order Summary Report, dated 5/10/18,			environments and necessary intervention to redirect behaviors before utilizing medications if medications are needed consistently MD to schedule if			
	identified an order for Lorazepam 0.5 mg (antianxiety) every four hours PRN for anxiety with a start date of 2/27/18. The order lacked a			medications needed ofte if not used. This will occu All residents have been r	n or discontinued ir every 14 days. eviewed for		
	duration for its use. R3's record lacked evidence of a physician's evaluation to extend the duration for use beyond 14 days.			current as needed psych appropriate use. Resider for sleep will have sleep No other residents were	ts on medication study completed.		
	indicated between mg was administer	Iministration record (MAR) 5/1/18, and 5/10/18, Ativan 0.5 ed on 13 occasions. From		policy on PRN psychotro monitoring been reviewe 3. To enhance currently	d and revised. compliant		
	administered on 50			operations and under the DON, on 6/6/2018 all nur receive in-service training	sing staff will g on utilizing PRN		
	(DON) verified R3's physician justification) p.m. the director of nursing s Ativan PRN order required a on and duration for the use d stated R3's physician should		psychotropic medications PRN for more than 14 da importance of physician of order continued use or so	ays and the doing visit to		
	have documented a for the continued us facility had not read	a clear rational and a duration se. The DON verified the ddressed R3's PRN Ativan		consistently, indicating ta noted in documentation, non-pharmacological app	rget behaviors and proaches.		
		ly hypnotic without adequate ensure efficacy and as		Psychotropic medications at quarterly and annual re determine need, effective reduction. 4. Effective 6/6/2018, a	eviews to eness or dose		
	R13 received a Tra and recommended study was complete	eview dated 4/24/18, identified izadone 50 mg (hypnotic) daily the facilty ensure a sleep ed. A note was faxed to R13's		quality-assurance progra implemented under the s pharmacy and nursing to residents with prn orders	upervision of monitor for psychotropic		
		ng an order for a sleep study in n responded with an order for a		meds and those on seda for monitoring of sleep st or designated quality-ass representative will perfor	udies. The DON surance		
		nary Report dated 5/9/18, lated 2/13/18, for Trazadone		systematic audits on resi for prn psychotropic and	dents with orders		

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	-	AND HUMAN SERVICES	1			APPROVEI . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	`´co∧	E SURVEY IPLETED
		245323	B. WING			R 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
WALKER	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PC WALKER, MN 56484	BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
{F 758}	 (hypnotic) 50 mg at depressive disorder order dated 10/1/15 monitor R13's sleep of every month. On 1st and ending on t sleep study per the facility's pharmacy of number of hours av of hours asleep dur behavioral changes brief summary. Hou 4:00 a.m. R13's care plan prin risk for sleep patter diagnosis of sleep of Trazadone for sleep to administer the m physician and to as and to offer non-phy such as a back rub relaxation music. R13's clinical record pattern study/docur initiated. On 5/9/18, at 12:32 room, seated in his asked, R13 denied On 5/9/18, at 1:32 p reviewed R13's clin unable to locate any related to a sleep p 	bedtime for insomnia and r. The report also included an b, which directed the staff to o pattern the first seven days e time a day starting on the he 8th of every month for recommendations of the consultant. Record the vake during the night, number ing the night, yes or no to a during the night-if yes, write a urs of stud will be 8:00 pm. to hted on 5/9/18, indicated at n disturbance due to disturbance and use of b. The plan directed the staff edication as ordered by the sess for adverse side effects armacological interventions , relaxation techniques, soft or d lacked evidence of a sleep mentation having been p.m. R13 was observed in his electric wheelchair. When any sleep disturbances. b.m. registered nurse (RN)-B ical record and stated she was y type of documentation	{F 7	 sleep studies; 50 % of residents months to ensure compliance Any deficiencies will be correspot, and the findings of the quality-assurance checks will documented, submitted and the monthly quality-assuranc meeting for further review or action. The Pharmacy and DON responsible for this POC. Completion date is 6/15/ 	s weekly x 2 e in this area. cted on the l be monitored at e committee corrective will be	

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		AND HUMAN SERVICES & MEDICAID SERVICES			I	FORM	06/25/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			X3) DATE COMF	E SURVEY PLETED
		245323	B. WING				२ 10/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 /ALKER, MN 56484	0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 810}	lacked evidence of stated the sleep pat not initiated when o Superior Healthcare Region policy and p identified the facility comply with state at to the use of psycho to include regular re appropriate dosage benefits. Additionall of determining the u symptoms so the ap environment, medic interventions, as we medications could b Assistive Devices - CFR(s): 483.60(g) §483.60(g) Assistive The facility must pro and utensils for resi appropriate assistan can use the assistive meals and snacks. This REQUIREMEN by: Based on observat review, the facility fa equipment in order eating for 1 of 1 resi	R13's sleep pattern and ttern study/documentation was rdered. Management Minnesota procedure dated 12/23/17, would make every effort to and federal regulations related opharmacological medications eview for continued need, side effect, risks and/or y, the facility supports the goal underlying cause of behavioral opropriate treatment of cal, and/or behavioral ell as psychopharmacological be utilized. Eating Equipment/Utensils	{F 7		F810 SS=D This Plan of Correction constitutes m written allegation of compliance for th deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of	ny he sion	6/15/18
	-	imum Data Set (MDS) dated			one was cited correctly. This Plan of Correction is submitted to meet requirements established by state an		

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	. ,	IG		PLETED
					F	۲
		245323	B. WING _		05/	10/2018
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
VALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
[F 810}	Continued From pa	ge 22	{F 81()}		
		23 with severe cognitive	(* * * *	federal law.		
		gnoses including dementia,		1. It is the policy of the facilit	y to provide	
	history of stroke an	d aphasia (inability to speak).		adaptive equipment to all resid		
		R23 required extensive		conjunction with OT to ensure		
		activities of daily living		remains as independent and h		
		23's annual MDS dated tified R23 as requiring		functioning as they can. R23 where a stress function for the stress function for the stress function of the stress		
	extensive assistance			adaptive silverware on care, o		
		in a samig.		Although adaptive equipment		
	R23's Nutritional St	atus Care Area Assessment		staff member assisting with m		
		17, indicated R23 displayed		to use with resident regardles		
	disruptive behavior	s and threw food during meals.		Upon notification by surveyor		
	P22's Occupations	Thorapy OT evaluation and		occurrence, discussed situation and ensured that all orders with		
		I Therapy OT evaluation and dated 4/17/18, indicated R23		followed as determined by res		
		ent upon staff for feeding and		care plan.		
		t or recommendations were		2. Because many residents		
	warranted.			adaptive devices many are po		
				affected by the cited deficienc		
		ited 1/20/18, indicated R23		discussed with administration		
		ered shaker cup for drinking n or silverware while eating.		determined based on faulty pr employee correction would be		
		for silver while while eating.		resident will always be able to		
	On 5/9/18, at 5:05	o.m. R23 was observed seated		utensils that best meet his nee		
		he dining room. Nursing		changes made by staff. All res		
		as assisting R23 with his meal.		adaptive devices have been re		
		ted spoon as she fed R23 the		use and appropriateness. No	other	
		ed of ground hamburger with macaroni and cheese. R23		residents were affected. 3. To enhance currently com	nliant	
		n the covered "shaker" cup		operations all staff will be upd		
	throughout the mea			in-service 6/6/2018 about ada		
	-At 5:55 p.m. R23 h	ad eaten 75% of the meal and		equipment and importance of	offering it or	
		nately 240 cc (cubic		alerting charge nurse if further		
	centimeters) of juic	e independently.		needed to find another option.		
	At 7.30 pm - 822's	room was not observed to		respect and dignity with and ir		
	have any type of wa	room was not observed to ater glass for R23		giving residents the tools they successful in their ADL□s.		
	have any type of Wa	ator glass 101 1120.		4. Effective 6/4/2018, a		

Facility ID: 00995

If continuation sheet Page 23 of 25

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT COM	0938-039 E SURVEY PLETED
		245323	B. WING			R 10/2018
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZI	P CODE	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WES WALKER, MN 56484	T PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
{F 810}	the dining room for coordinator (HUC) toast, juice and mill coated spoon as sh "shaker" cup was of assisted R23 to drift time throughout the be encouraged to u -At 9:00 a.m. R23 h breakfast meal and liquids. The HUC of clean unused cover did not like the cover did not like the cover fine without it so sh the covered cup. The utilized the adaptive the dining room. -At 10:00 a.m. R23 water glass or fluids room. -At 11:30 a.m. the of confirmed R23 was and the coated spo plan. The DON state adaptive eating equipment all residents were to in their rooms inclu- adaptive equipment -At 12:00 p.m. the of the coated spo	breakfast. The health unit was served R23 hot cereal, k. The HUC utilized the he fed R23. R23's covered in the table, however, the HUC hk from a standard cup. At no e meal was R23 observed to atilize the covered cup. had finished 100% of the l approximately 50% of the cleared the table including the red cup. The HUC stated she ered cup and R23 drank just e felt R23 did not need to use he HUC confirmed she had not e equipment as identified on proceeded to wheel R23 out of 's room was observed. A s were not observed in R23's director of nurses (DON) is to utilize the covered cups on as directed on the care tted she was unaware R23's uipment was not being utilized R23's room. The DON stated o have water or fluids available ding residents who required	{F 81	0} implemented under the sidietary manager to monit devices and residents ner assistance. The dietary r designated quality-assurar representative will perforr systematic changes: audi with adaptive devices or r for all meals for first week per resident per week x 4 audit x2 months to ensure this area. Any deficiencie corrected on the spot, and the quality-assurance cher documented and submitte quality-assurance commin further review or corrective 5. All staff will be respon POC. 6. Compliance date is 6	or adaptive eding nanager or ance its on residents needing devices then 3 audits weeks, then 1 e compliance in s will be d the findings of ecks will be ed at the monthly ttee meeting for re action. nsible for this	

If continuation sheet Page 24 of 25

		AND HUMAN SERVICES					FORM	06/25/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR			(X3) DATE COMI	E SURVEY PLETED
		245323	B. WING					२ 10/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE,	ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			WOOD AVENUE WE MN 56484	EST PO BOX 7	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (E CRC	PROVIDER'S PLAN O ACH CORRECTIVE AC DSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
{F 810}		ge 24 equipment to assist residents sier independent eating.	{F 8					

Facility ID: 00995

If continuation sheet Page 25 of 25



Protecting, Maintaining and Improvingthe Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on June 27, 2018.

June 27, 2018

Mr. Brian Reindl, Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West PO Box 700 Walker, MN 56484

Re: Project # S5323027

Dear Mr. Reindl:

On May 10, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 27, 2018 with orders received by you electronically on April 26, 2018.

State licensing orders issued pursuant to the last survey completed on March 27, 2018 and found corrected at the time of this May 10, 2018 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on March 27, 2018, found not corrected at the time of this May 10, 2018 revisit and subject to penalty assessment are as follows:

20895 MN Rule 4658.0525 Subp. 2.B Rehab - Range Of Motion	\$350.00
20900 MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	\$350.00
20910 MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	\$350.00
20945 MN Rule 4658.0530 Subp. 1 Assistance With Eating - Nursing Personnel	\$350.00
21426 MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	\$ 0.00
21540 MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring	\$300.00

The details of the violations noted at the time of this revisit completed on May 10, 2018 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$1700.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Shellae Dietrich, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

Minneso	ota Department of He	ealth			I OTAMA THOULD
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00995	B. WING		R 05/10/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
WALKE	R REHABILITATION &			ENUE WEST PO BOX 700	
			MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{2 000}	Initial Comments		{2 000}		
	****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section action order has been issued ey. If, upon reinspection, it is sciency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.			
	corrected requires requirements of the number and MN Re When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was			
	that may result fror orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.			
Minnesoto	and 10, 2018. Dur that the following c Corrected: 0895, 0 1540. These uncor effect and will be re assessment/s.	TS: o visit was completed on May 9 ing this visit it was determined orrection orders were NOT 900, 0910, 0945, 1426, and rected orders will remain in eviewed for possible penalty		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned to Minnesota state statutes/rules for N Homes.	D
	epartment of Health Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

Electronically Signed

06/06/18

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If continuation sheet 1 of 29

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	·	,	
		00995	B. WING	R 05/10/2018		
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C		ENUE WEST PO BOX 700		
		WALKE	R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
{2 000}	Continued From pa	ge 1	{2 000}			
				The assigned tag number app far left column entitled "ID Pro- The state statute/rule number corresponding text of the state out of compliance is listed in t "Summary Statement of Defice column and replaces the "To 0 portion of the correction order column also includes the find are in violation of the state state statement, "This Rule is not m evidenced by." Following the findings are the Suggested Ma Correction and the Time Perio Correction.	efix Tag." and the e statute/rule he ciencies" Comply" This dings which tute after the net as surveyors ethod of od For	
				THE FOURTH COLUMN WH STATES, "PROVIDER'S PLAI CORRECTION." THIS APPLI FEDERAL DEFICIENCIES OI WILL APPEAR ON EACH PA THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRE	ICH N OF ES TO NLY. THIS GE. NT TO	
				VIOLATIONS OF MINNESO STATUTES/RULES.	TA STATE	
{2 895}	MN Rule 4658.0528 Motion	5 Subp. 2.B Rehab - Range of	f {2 895}			6/15/18
	that is directed towa through positioning implemented and n comprehensive res of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the directo must coordinate the ursing care plan which				

RI9312

If continuation sheet 2 of 29

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		R 05/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
		209 BIR		ENUE WEST PO BOX 700		
WALKER	REHABILITATION &	WALKEF	R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
{2 895}	Continued From pa	age 2	{2 895}			
	receives appropriat	th a limited range of motion te treatment and services to notion and to prevent further of motion.				
by Ur ori	by: Uncorrected based original licensing or	ent is not met as evidenced on the following findings. The der issued on 3/27/18, will enalty assessment issued.		2895 🗆 see F688		
	review, the facility f range of motion (Re residents (R23) obs without the assess ROM program in or maintain current Ro facility failed to follo related to the applie	ion, interview and document ailed to assess the need for OM) services for 1 of 3 served with limitations in ROM ment and development of a rder to prevent a decline or OM abilities. In addition, the bw the therapist's direction cation of splints for 1 of 1 was currently receiving by.				
	Findings include:					
	3/9/18, indicated R: impairment and dia dementia, history o to speak). The MD extensive assistant living. R23's annua	imum Data Set (MDS) dated 23 had severe cognitive ignoses which included f stroke and aphasia (inability S indicated R2 required ce with all activities of daily I MDS dated 10/13/17, ired total staff assistance for r living.				
	staff to have physic	ovided on 5/10/18, directed the al therapy (PT) and by (OT)evaluate and treat R23				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00995	B. WING	B. WING		R 05/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
NALKEF	R REHABILITATION &			NUE WEST PO BOX 700			
		WALKEF	R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
{2 895}	Continued From pa	age 3	{2 895}				
	directed the staff to immobility, or contr	ohysician. The care plan also o report signs and symptoms or actures forming or worsening. not direct the staff to assist R23 s.	f				
	Summary dated 4/ extremity limitations therapist indicated R23 ROM with mar	ogress and Discharge 13/17, indicated R23 had lower s in ROM. The physical nursing staff was to provide nual stretches including s. The frequency of the indicated.	r				
	summary dated 4/1 limitation in ROM ir occupational therap	ogress and Discharge 14/17, indicated R23 had in the upper extremities. The pist indicated R23 was to cises however, the frequency is not identified.					
	4/17/18, indicated I for feeding assistar	on and Plan of Treatment dated R23 had been evaluated by OT nce devices, but did not include valuation or directions for a n.	г				
		ty's Restorative nursing not include a restorative r R23.					
		ectronic medication record did to assist with ROM.					
	transferred from the full body mechanic nursing assistant (I and pants were obs	p.m. R23 was observed to be e wheelchair to the bed via a al lift with the assistance of NA)-B and NA-C. R23's shirt served to be saturated with NA's changed his clothing.					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _				
		00995	B. WING			R 05/10/2018	
ME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ALKER	REHABILITATION &	HEALTHCARE C		NUE WEST PO BOX 700			
X4) ID	SUMMARY STA		R, MN 56484	PROVIDER'S PLAN OF	CORRECTION	(X5)	
REFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET	
2 895}	Continued From pa	age 4	{2 895}				
	kicked at staff with his pants, NA-B mo revealed no limitati R23 to change his to have full ROM in left arm moved app limitation in ROM ir On 5/10/18, at 11:4 (DON) stated R23 for ROM needs, ho added to the therap evaluation dated 4/ R23's ROM needs should have been. On 5/10/18, at 1:15 occupational therap R23 had been eval	by assistant (COTA)-A stated uated for his adaptive t meals, however, R23 was					
	R5's quarterly MDS had moderate cogr diagnoses which in quadriplegia and de R5 required total as mobility, transfers a and had bilateral fu motion of the upper admission MDS da dependent upon sta living and had bilate ROM of the upper a R5's Activities of Da Assessment (CAA)	6 dated 1/10/18, indicated R5 nitive impairment and cluded Parkinson's disease, epression. The MDS indicated and all activities of daily living, inctional limitation in range of r and lower extremities. R5's ted 9/1/17, indicated R5 was aff for all activities of daily eral functional limitation in and lower extremities. aily Living Care Area o dated 9/6/17, indicated R5 assistance all activities of daily					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00995	B. WING		R 05/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKEF	R REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
{2 895}	Continued From pa	ige 5	{2 895}			
		ction), spinal fusion and AA indicated R5 was apy.				
	of Treatment dated had bilateral arm co treated by OT for th implementation of i contractures. The indicated R5 was to and a resting pan-r splints for greater t and symptoms of re pain. The long terr	Therapy Evaluation and Plan 4/8/17-5/7/18, indicated R5 ontractures and was being ne evaluation and nterventions to minimize arm identified short term goal o utilize a resting hand splint nitt splint and elbow extension han eight hours without signs edness, swelling, discomfort of n goal was to ensure R5 was lints without redness or				
		Therapy Treatment Encounter following information:				
	completed, applied - 4/12/18, PROM to applied. - 4/16/18, PROM to expressed discomf					
	splints applied.	 the upper extremities and upper extremities and splints fit 				
	- 4/23/18, PROM to splints. - 4/25/28, PROM a present for proper a	nd educated nursing staff application of splints. educated staff on prolonged				
	stretches and splin - 4/30/18, PROM a - 5/1/18, PROM an	t application. nd splint application.				

STATE FORM

RI9312

If continuation sheet 6 of 29

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		00995	B. WING			R 05/10/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
		209 BIRC	HWOOD AVE	NUE WEST PO BOX 700			
VALKER	REHABILITATION &	HEALTHCARE CI WALKER	, MN 56484				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T		COMPLET DATE	
		· · · · · · · · · · · · · · · · · · ·		DEFICIENC	Y)		
{2 895}	Continued From pa	nge 6	{2 895}				
	NA's on proper place	cement of splints					
		h stretches, communicated					
		ation of splints and prolonged					
	stretching for R5.	1 1 3					
	- 5/8/18, PROM and	d application of elbow and					
	hand splints.						
	Dovious of DE'o Dro	gress note dated 4/30/18,					
		nad removed R5's right braces					
	due to the knuckles						
	DE'a coro plon prov	ided on 5/10/19 included					
		vided on 5/10/18, included 9/18, which directed the staff:					
		g pillows to position arms in					
		emind to extend throughout the					
	day. Washcloths in						
	On 5/9/18. at 1:00 r	p.m. R5 was observed seated					
		is room. R5's arms were					
	noted to be contract	ted at the elbows, wrists,					
		rs. R5 was not utilizing any					
	type of braces.						
		as observed in bed, no splints					
	were observed.	as transferred from bed to					
		l body mechanical lift. NA-C					
		ansfer. Once in the chair,					
		erved to encourage R5 to do					
		es and pillows were not placed.					
	- At 7:10 p.m. NA-0	G assisted to transfer R5 from					
		ed and complete bedtime					
		ot apply any type of brace,					
	•	hs into R5 hands. NA-G					
		tilize splints, however, NA-G ate the splints as they were not					
		S stated she had not received	•				
	any new directions						
		sed practical nurse (LPN)-C					
		tilize hand splints at bedtime.					

ND PI AN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _	A. BUILDING:		R	
		00995	B. WING			к 10/2018	
AME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
ALKER	REHABILITATION &		CHWOOD AVEI 2, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 895}	Continued From pa	age 7	{2 895}				
	recorded on the elek however, they had she had not receive related to R5's con- shift report. On 5/10/18, at 7:05 in a wheelchair in h to be contracted, new wer observed to be - At 7:08 a.m. NA-E informed of new pil NA-B stated the Re Services had expla for R5's comfort but how they were to b not have washcloth assisted him out of complete PROM for to be extend to a 90 the shoulder was a 2-3 inches, the wris and the fingers of t be opened more th held the right hand elbow moved to ab wrist, fingers and s When NA-B had co	B stated she had been low placements for R5's arms. egional Director of Clinical ined how to place the pillows it she could not recall exactly e placed. NA-B stated R5 did is in his hands when she bed. NA-B proceeded to or R5. R5's right arm was able 0 degree angle at the elbow, ble to be moved approximately st was unable to be straighten he right hand were unable to an an inch from the palm. R5 in a fisted position. The left out a 90 degree angle, the houlders were contracted. ompleted the exercises, she ler R5's elbows to extend them					
	dining room. R5 di place at the time of						
	comprehensive ass	ical record lacked a sessment of the he splints and the application					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or contraction	IDENTIFICATION NOWIDER.	A. BUILDING:			
00995		00995	B. WING		R 05/10/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
NALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVE	NUE WEST PO BOX 700		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
{2 895}	Continued From pa	age 8	{2 895}			
	discontinued the sp directed the staff to The DON stated th	DON stated the therapist had plints on 5/9/18, and had o use pillows and washcloths. e staff were to have been ange via shift report and the				
	wheelchair in his ro clinical services co	observed seated in his oom. The regional director of nfirmed R5 did not have directed. the regional director under R5's arms.				
	COTA and the region had reviewed R5's discontinue them we to discontinuation. contacted the OT and discontinuation of F was "unhappy" with not initiated the char not yet been discont therapy. COTA-As	A-A stated an unidentified onal director of clinical services splints yesterday and chose to vithout contacting the OT prior COTA-A stated she had and informed her of the R5's splints and stated the OT on this change as the OT had ange in treatment and R5 had optimud from occupational stated the OT was returning to lete an additional evaluation of				
	OT-A was not avail survey.	able for interview during the				
	4/2/18, directed the joints and muscles, staff to verify a phy received and if ther to contact the atten order, as needed. I	on Exercises policy dated e staff to exercise the residents . The policy also directed the sician order for ROM had been re was no order, the staff were iding physician to obtain an n addition the staff were he following in the resident				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
					R	
		00995	B. WING		05/	10/2018
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, S			
VALKER	REHABILITATION 8		R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
{2 895}	Continued From pa	age 9	{2 895}			
	clinical record:					
	 The type of ROM Whether the exer How long the exer If and how the resprocedures or any ability to participate Any problems or residents related to 	person providing the exercise exercises. rcise was active of passive. rcise was conducted. sident participated in the changes in the resident's e. complaint made by the o the procedure. used the treatment and reaso				
{2 900}	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	{2 900}			6/15/18
	comprehensive res of nursing services	sores. Based on the sident assessment, the directo must coordinate the nursing care plan which	Dr			
	without pressure s pressure sores unl condition demonst	to enters the nursing home cores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores by treatment and services to revent infection, and prevent veloping.				
	by:	ent is not met as evidenced I on the following findings. Th				
	I Incorrected bacas			2900 🗆 see F686		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00005	B. WING			R	
		00995			05/	10/2018	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
VALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
{2 900}	Continued From pa	age 10	{2 900}				
	original licensing order issued on 3/27/18, will remain in effect. Penalty assessment issued.						
	review, the facility f repositioning assist plan for 2 of 3 resid	ion, interview and document ailed to provide timely tance as directed by the care dents (R5, R23) reviewed who pressure ulcers and required repositioning.					
	Findings Include:						
	assessment dated moderate cognitive including Parkinsor depression. The M assistance of two s living including bed	mum Data Set (MDS) 1/10/18, indicated R5 had impairment and diagnoses o's disease, quadriplegia and IDS indicated R5 required tota taff for all activities of daily mobility and transfers. The I R5 as at risk for development					
	(CAA) dated 9/6/17 development of pre- dependence upon s management of bo assessment indicat weekly skin assess	er Care Area Assessment 7, identified R5 as at risk for essure ulcers due to staff for repositioning, and wel incontinence. The ted staff were to complete sments and were to monitor isting with personal cares.					
	pressure ulcer deve	(a tool utilized to predict elopment) dated 5/8/18, risk for development of					
	5/9/18, indicated Range area over boney pr	nce Observation form dated 5 displayed a "slightly red" ominences. However, the form ch boney prominences had	n				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00995		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 05/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	•	
VALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 900}	skin care directives R5's care plan provinterventions for starepositioning at leas On 4/27/18, at 4:27 was observed to traving wheelchair via a ful -At 5:05 p.m. R6 wa room for supper	otibility to pressure nor any for the staff to implement. rided on 5/10/18, included aff to assist R5 with st every two hours. f p.m. nursing assistant (NA)-C ansfer R5 from bed into a I body mechanical lift. as wheeled into the dining	{2 900}			
	evening meal. -At 5:40 p.m. R5 wa room and to his roo -At 6:00 p.m. until 7 room, seated in the -At 7:05 p.m. NA-G to assist R5 with ev -At 7:15 p.m. NA-G wheelchair to bed. observed equipped	7:05 p.m. R5 remained in his wheelchair. entered R5's room and begar				
	was noted to have fragile like skin cov -At 7:30 pm. NA-G last time R5 had be NA-G stated she ha p.m. and had not re	a small crevasse with thin, ering it. stated she was unaware of the een assisted with repositiong. ad arrived at the facilty at 6:00 eceived any type of shift report d assistance with repositioning				
	transfer R5 from th body mechanical lif -At 10:55 a.m. the o stated R5 was to re	a.m. NA-F was observed to e wheelchair into bed via a full t. director of nursing (DON) eceive assistance with wo hours as directed by the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING			R 05/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, SI	TATE, ZIP CODE			
		209 BIR(NUE WEST PO BOX 700			
WALKER	R REHABILITATION &	WALKEF	R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 900}	Continued From pa	age 12	{2 900}				
		e timely assistance with ater than four hours on the					
	had severe cognitive which included dem aphasia (inability to R23 required exten mobility and transfe development of pre MDS dated 10/13/1 totally dependent u	OS dated 3/9/18, indicated R23 ve impairment and diagnoses nentia, history of stroke and o speak). The MDS indicated ners and was at risk for the essure ulcers. R23's annual 17, also identified R23 as being pon staff for bed mobility, k for the development of					
	identified R23 at ris pressure ulcers and pressure reducing	cer CAA dated 10/9/17, sk for the development of d directed the staff to utilize a mattress, chair cushion, and to oading every two hours and as					
	Sore Risk dated 5/8	e for Prediction of Pressure 8/18, identified R23 at ne development of pressure					
		nce Observation Tool dated 23 did not develop reddened urs in one position.					
		ovided on 5/10/18, directed repositioning every two hours.					
	4:20 p.m. to 8:20 p receive assistance	observations on 5/9/18, from .m. R23 was not observed to with repositiong. and NA-A were observed to					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING			10/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVE , MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{2 900}	Continued From pa	ge 13	{2 900}			
	body mechanical lif -At 5:05 p.m. regist R23 to the dining ro -At 5:22 p.m. NA-A meal. -At 6:19 p.m. R23 w -At 6:30 p.m. until 7 room, seated in the -At 7:40 p.m. NA-G facility at 6:00 p.m. of report when she not know when R23 NA-G stated she we -At 8:00 p.m. R23 m wheelchair. -At 8:15 p.m. NA-A R23 as she was bu residents. NA-A sta assisted with repos -At 8:20 p.m. the Do of Clinical Services with repositiong by the full body mecha director stated she out of the chair with any type of repositio into the chair. -At 8:25 p.m. the Do approached R23 in to a full body mecha room and assisted Clinical Services to wheelchair to the bo equipped with a pre R23's buttocks wer- -At 8:26 p.m. NA-A	ered nurse (RN-B) wheeled bom. assisted R23 with the evening vas wheeled into his room. C:40 p.m. R23 remained in his wheelchair. stated she had arrived at the and had not received any type arrived at the facility and did b had last been repositioned. ould try to get to him. emained seated in the stated she could not assist sy answering lights for other ated R23 had not yet been itioning/cares. ON and the Regional Director stated they had assisted R23 lifting him out of the chair with mical lift sling. The regional and the DON had lifted him the lift but did not complete oning, rather R23 back down ON and regional director his room and connected him anical lift. NA-A entered the the Regional Director of transfer R23 from the ed. R23's wheelchair was assure redistribution cushion.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
					R	
		00995	B. WING	B. WING		10/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NALKEF	R REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	COMPLET DATE
{2 900}	Continued From pa	age 14	{2 900}			
	was to receive assi two hours as direct DON stated when s clinical services has the mechanical lift for only 10-30 seco order for full tissue the resident would prominences for a	0 a.m. the DON stated R23 istance with repositiong every ed by the plan of care. The she and the regional director of d repositioned R23 by lifting sling, R23 was out of the chair onds. The DON confirmed in perfusion to be accomplished, have to be off of the bony minimum of one minute. The 23 had not been out of the chair				
	Region policy and p Risk Assessment e following: -pressure ulcers ar resident remained i extended period of pressure or decrea -if pressure ulcers ar discovered, they ca infected -pressure ulcers ar continual pressure, substances on the soap, discharge), d hydration status, ac resident's physical -pressure ulcers ar the resident -routinely assess at the resident's skin p care program for an irritation or breakdo -Skin would be ass	are not treated when an become larger, painful, and e often made worse by , heat, moisture, irritating resident's skin (feces, urine, lecline in nutrition, and cute illness or decline in the and/or mental condition e a serious skin condition for nd document the condition of per facility wound and skin ny signs and symptoms of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R		
		00995	B. WING		05/10/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
VALKER	R REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLET DATE	
{2 900}	Continued From pa	age 15	{2 900}				
	Region, Reposition reviewed 4/2/18, in procedure was to p evaluation of reside in the development for repositioning, to chair bound reside breakdown, promo pressure relief for r indicated reposition who was immobile repositioning. A rep defined as a specif	chcare Management Minnesota ing policy and procedure dicated the purpose of the provide guideline for the ent repositioning needs, to aid t of an individualized care plan promote comfort for all bed o ints and to prevent skin te circulation and provide residents. The policy also ning was critical for a resident or dependent on staff for positioning program was ic approach that was I, documented, monitored and					
{2 910}	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	{2 910}			6/15/18	
	have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: /ho enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as ler function as possible.					

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		R 05/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
{2 910}	Continued From pa	ge 16	{2 910}			
	by: Uncorrected based original licensing or	ent is not met as evidenced on the following findings. The der issued on 3/27/18, will enalty assessment issued.		2910 🗆 see F810		
	Based on observati review, the facility f assistance with inco	ion, interview and document ailed to provide timely ontinence cares for 1 of 3 o was totally dependent on				
	Findings include:					
	3/9/18, identified R2 impairment and dia history of stroke an The MDS indicated assistance with all a indicated he was to R23's annual MDS	imum Data Set (MDS) dated 23 with severe cognitive gnoses including dementia, d aphasia (inability to speak). R23 required extensive activities of daily living and tally incontinent of bladder. dated 10/13/17, also identified y incontinent of bowel and				
	identified R23 as be bowel and bladder	ntinence CAA dated 10/9/17, eing totally incontinent of and directed the staff to assist ge R23's incontinence brief				
		ovided on 5/10/18, directed change R23's incontinence rs.				
	4:20 p.m. to 8:20 p. receive assistance -At 4:20 p.m. nursir	observations on 5/9/18, from m. R23 was not observed to with incontinence cares. ng assistant (NA)-C and NA-A ansfer R23 from bed to a				

	NT OF DEFICIENCIES OF CORRECTION	2011h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00995	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 05/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
{2 910}	Continued From pa	ge 17	{2 910}			
	-At 5:05 p.m. register R23 to the dining ro- At 5:22 p.m. NA-A meal. -At 6:19 p.m. R23 w remained in his roo until 7:40 pm. -At 7:40 p.m. NA-G facility at 6:00 p.m. of report when she when R23 had last incontinence cares. get to him. -At 8:00 p.m. R23 o wheelchair. -At 8:15 p.m. NA-A R23 as she was bu residents. NA-A co assisted with incom -At 8:20 p.m. the di the Regional Direct approached R23 ar mechanical lift. NA assisted the Regior to transfer R23 from -At 8:26 p.m. NA-A R23 was observed NA-A confirmed R2 incontinence cares minutes earlier. On 5/10/18, at 11:3 was to receive assis every two hours as The Toileting policy directed the staff to a timely manner in a	assisted R23 with the evening vas wheeled into his room and m, seated in the wheelchair, stated she had arrived at the and had not received any type arrived and did not know been assisted with . NA-G stated she would try to continued to be seated in the stated she could not assist sy answering lights for other infirmed R23 had not yet been tinence cares. rector of nursing (DON) and or of Clinical Services and connected him to a full body A entered the room and hal Director of Clinical Services in the wheelchair to the bed. completed perineal cares. to be incontinent of urine. 3 had last been assisted with at 4:20 p.m. 4 hours and 6 0 a.m. the DON stated R23 stance with incontinence cares directed by the plan of care.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (>	(3) DATE SURVEY COMPLETED
		00995	B. WING		05/10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
WALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVI MN 56484	ENUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
{2 910}	utilization of the toil	as unable to physically tolerate et, the staff were to adhere to e program based on a bowel	{2 910}		
{2 945}	Eating - Nursing Per Subpart 1. Nursing personnel must det served diets as pre help in eating must receipt of the meals unhurried and in a enhances each res Adaptive self-help of contribute to the res eating. Food and fl be observed and de	D Subp. 1 Assistance with ersonnel g personnel. Nursing termine that residents are scribed. Residents needing be promptly assisted upon s and the assistance must be manner that maintains or ident's dignity and respect. devices must be provided to sident's independence in luid intake of residents must eviations from normal se responsible for the	{2 945}		6/15/18
	resident's care duri observation of a de unresolved problem attending physician	ng the work period the viation was made. Persistent is must be reported to the			
	original licensing or remain in effect. Pe Based on observati review, the facility f equipment in order	on the following findings. The der issued on 3/27/18, will enalty assessment issued. ion, interview and document ailed to provide adaptive to promote independence with sident (R23) reviewed for		2945 see correction 810	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:	·····	R
		00995	B. WING		05/10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
WALKER	R REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE DATE
{2 945}	Continued From pa	age 19	{2 945}		
	nutrition and obser and drinking.	ved to display difficulty eating			
	Findings include:				
	3/9/18, identified R impairment and dia history of stroke an The MDS indicated assistance with all including eating. R	nimum Data Set (MDS) dated 23 with severe cognitive agnoses including dementia, ad aphasia (inability to speak). I R23 required extensive activities of daily living 23's annual MDS dated tified R23 as requiring ce with eating.			
	(CAA) dated 10/20	tatus Care Area Assessment /17, indicated R23 displayed s and threw food during meals			
	Plan of Treatment was totally depended	I Therapy OT evaluation and dated 4/17/18, indicated R23 ent upon staff for feeding and t or recommendations were			
	was to utilize a cov	ated 1/20/18, indicated R23 ered shaker cup for drinking n or silverware while eating.			
	in a wheelchair, in assistant (NA)-A wa NA-A utilized a coa meal which consist gravy, broccoli and	p.m. R23 was observed seated the dining room. Nursing as assisting R23 with his meal. ted spoon as she fed R23 the red of ground hamburger with macaroni and cheese. R23 n the covered "shaker" cup al.			
	-At 5:55 p.m. R23 h	nad eaten 75% of the meal and nately 240 cc (cubic			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		R	
		00995	B. WING			10/2018
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
{2 945}	Continued From pa	age 20	{2 945}			
	-At 7:30 p.m. R23's have any type of wa	room was not observed to ater glass for R23.				
	the dining room for coordinator (HUC) toast, juice and mill coated spoon as sh "shaker" cup was o assisted R23 to drift time throughout the	a.m. R23 was wheeled into breakfast. The health unit was served R23 hot cereal, k. The HUC utilized the fed R23. R23's covered on the table, however, the HUC nk from a standard cup. At no e meal was R23 observed to utilize the covered cup.				
	breakfast meal and liquids. The HUC of clean unused cover did not like the cover fine without it so sh the covered cup. The utilized the adaptive	had finished 100% of the l approximately 50% of the cleared the table including the red cup. The HUC stated she ered cup and R23 drank just he felt R23 did not need to use he HUC confirmed she had no e equipment as identified on proceeded to wheel R23 out of				
		's room was observed. A s were not observed in R23's				
	confirmed R23 was and the coated spo plan. The DON sta adaptive eating equ during meals or in I all residents were to	director of nurses (DON) to utilize the covered cups on as directed on the care ated she was unaware R23's upment was not being utilized R23's room. The DON stated o have water or fluids available ding residents who required t.	\$			
		dietary director was observed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED
		00995	B. WING	05	/10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
VALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVE , MN 56484	NUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
{2 945}	Continued From pa	age 21	{2 945}	· · · · · · · · · · · · · · · · · · ·	
	to place a covered	cup of water in R23's room.			
	Equipment policy d to provide adaptive	e Management Adaptive ated 4/2/18, directed the staff equipment to assist residents asier independent eating.			
{21426}	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	{21426}		6/15/18
	maintain a compre- infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ad States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must ne nursing home.			
	by: Uncorrected based original licensing or	ent is not met as evidenced on the following findings. The rder issued on 3/27/18, will enalty assessment issued.		21426 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission c	of

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	NSTRUCTION	(X3) DATE S COMPL	
	00995		B. WING	R 05/10/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STATE			
				E WEST PO BOX 700		
WALKEF	R REHABILITATION &	HEALTHCARE C	, MN 56484			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
{21426}	Continued From pa	age 22	{21426}			
	Based on interview facility failed to ens of 5 employees (ad received a two-step and/or TB prescree Centers for Disease (CDC). Findings include: The CDC Guideline Transmission of My Health Care Setting residents must rece The baseline TB so assessment for TB assessment for cur and testing for the p mycobacterium tub screenings, the res receive a two-step laboratory screenin employee or reside aforementioned tes medical examinatio was to be complete Resident: During the original noted that R10 was 6/20/17. R10's Bas Nursing Home and Residents dated 6/2 received a single st the onsite follow up	and document review, the ure 1 of 1 resident (R10) and 2 liministrator, NA-G) reviewed tuberculin skin test (TST) ening in accordance to the e Control and Prevention es for Preventing the vobacterium Tuberculosis in g, 2005, directed that all eive a baseline TB screening. creening should consist of risk factors and history, rrent symptoms of active TB, presence of infection with erculosis. In addition to idents and employees were to tuberculin skin test (TST) or a g for the presence of TB. If an ent tested positive for any of sts, a chest x-ray and/or on by a medical practitioner ed to rule out active disease. survey exited 3/27/18, it was admitted to the facility on seline TB screening Tool for Boarding Care Home 20/17, indicated R10 had tep TST on 6/30/17. During o visit exited 5/10/18, R10's	this that cite sul esi 1. eff reg any the acl TB adu be up 2. rec tesi mo ve err mis col be 3. op on tra ste to f the ster f H H F	s Plan of Correction is not at a deficiency exists or that ad correctly. This Plan of bonitted to meet requirement tablished by state and fed it is the policy of the faci ective infection control pro- gard to tuberculosis screen d residents per CDC guide e many ways that this has hieved for R10 was to com- test and also completed and also completed and residents and NA. Emplo- en completed and resident dated. Because all residents an quired to have necessary b sting, all are affected by tho politoring of this system. Re- re reviewed for compliance aployee files. All staff and ssing Mantoux tests have trected. The policy on trace en reviewed and updated. To enhance currently con- erations and under the reg 6/6/2018 all staff will rece ining for appropriate proce op Mantoux a staff will rece ining emphasizes the risk ins and symptoms of mon- Effective 6/4/2018, a ality-assurance program v plemented under the super R director to monitor emplo- acempliance and the infor-	at one was Correction is ents eral law. lity to provide ogram in ning to all staff elines. One of been nplete 2 step on oyee files have at chart is ad staff are oaseline e lack of esident charts been ch care has mpliant gional nurse, ive in-service edure for 2 ing/monitoring re on file. The of TB and itoring.	
	medical record con	visit exited 5/10/18, R10's tinued to lack evidence of a nd step TB testing having	for nu dir	R director to monitor emplo compliance and the infec rse or designee to monitor ector of nurses or designa ality-assurance representa	tion control r staff. The ated	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		BERTH TO THOMBEN.	A. BUILDING:		R 05/10/2018	
00995		00995	B. WING			
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
VALKER	REHABILITATION &		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
[21426}	Continued From pa	age 23	{21426}			
	Employees::			perform the following system		
	Nursing assistant (NA)-G was hired on 3/6/18.		all residents and all staff will and corrected immediately if		
		ecord did not include a		compliance. A checklist will of		
	screening for TB or			discrepancies and be put int correction as well as correct	o plan of	
	The Administrator V	was hired on 5/7/18. The		immediately by initiating 2 st		
		ployee record lacked evidence		chest x-ray if required. The f		
	of a two step TST t	est having been conducted.		quality-assurance checks wi documented and submitted		
	On 5/10/18, at 2:30) p.m. the regional director of		quality-assurance committee		
		DCS) confirmed R10's TB		further review or corrective a		
		npleted. In addition, the RDCS 0 had been cited for lack of TE		5. ED, nursing and HR will responsible for this POC.	be	
		nitial survey exited on 3/27/18,	,			
	she was not aware	of this deficient practice until				
		ed with the surveyor. The ned NA-G's TB screening had				
	not been complete					
		p.m. the Administrator				
	confirmed his empl of the two step TST	loyee record lacked evidence r test.				
		ey, the administrator faxed				
		tep TB test having been 7, at his previous place of				
		ver, there was no evidence a				
		ad been conducted.				
	A Tuberculosis poli was provided.	cy was requested and none				
{21540}	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	{21540}			6/15/18
		g. A nursing home must				
		ent's drug regimen for usage, based on the nursing				

RI9312

If continuation sheet 24 of 29

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	:	
		00995	B. WING		R 05/10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
NALKEF	R REHABILITATION &		HWOOD AV 8, MN 56484	ENUE WEST PO BOX 700	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE DATE
{21540}	Continued From pa	age 24	{21540}		
	pharmacist must re- resident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is the medical director physician does not the order and if the change the order, t review to the Qualiti (QAA) committee re- the attending physic	d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter			
	by: Uncorrected based original licensing or	ent is not met as evidenced on the following findings. The der issued on 3/27/18, will enalty assessment issued.		21540	
	review, the facility f (PRN) antianxiety r rational for the cont exceeding 14 days received PRN antia justification for its u addition, the facility pattern for 1 of 1 re received a daily hyp	ion, interview and document ailed to ensure an as needed nedication had a documented tinued use of the medication for 1 of 1 resident (R3) who anxiety medication without the use longer than 14 days. In failed to monitor the sleep esident (R13) reviewed who ponotic without adequate re medication efficacy and as sician.			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	СОМ	E SURVEY PLETED
	00995		B. WING			R 10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{21540}	Continued From pa	ige 25	{21540}			
	Findings include:					
		ed 5/10/18, included failure and chronic respiratory				
	(PMR) dated 4/19/1 related to the Center Services (CMS) reg clear risk vs. benefit to be in place to wa PRN psychotropic r and unfortunately h these regulation. Th indicated to the phy providing clinical do need and consider the patient's quality scheduling medicat past. The physician rejected the recommis	armacist's Medication Review 18, identified an irregularity er for Medicare/Medicaid gulations which required a it analysis and documentation arrant the continuation of a medication beyond 14 days tospice orders are included in the recommendation further vsician, to please consider bocumentation of continued how you feel it could improve of live. Could consider tion as was scheduled in the d's response dated 4/24/18, mendation and indicated the as needed nature of the order this hospice patient and bodiazepine was not				
	identified an order f (antianxiety) every with a start date of duration for its use.	ary Report, dated 5/10/18, for Lorazepam 0.5 mg four hours PRN for anxiety 2/27/18. The order lacked a R3's record lacked evidence aluation to extend the duration days.				
	indicated between a mg was administer	ministration record (MAR) 5/1/18, and 5/10/18, Ativan 0.5 ed on 13 occasions. From 3, Ativan 0.5 mg was				

ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		A. BUILDING:	·····		R	
	00995	B. WING			10/2018	
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ALKER REHABILITATION &		CHWOOD AVE	NUE WEST PO BOX 700			
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21540} Continued From pa	age 26	{21540}				
 (DON) verified R3¹/₂ physician justificati beyond 14 days an have documented for the continued u facility had not read order with the physician sleep monitoring to directed by the phy R13's Pharmacy read R13's Pharmacy read R13's Pharmacy read R13's complet physician requesting which the physician sleep study. 	Ily hypnotic without adequate o ensure efficacy and as visician. eview dated 4/24/18, identified azadone 50 mg (hypnotic) daily I the facilty ensure a sleep ed. A note was faxed to R13's ng an order for a sleep study in n responded with an order for a					
included an order of (hypnotic) 50 mg a depressive disorder order dated 10/1/1 monitor R13's slee of every month. Or 1st and ending on sleep study per the facility's pharmacy number of hours a of hours asleep du behavioral changer	hary Report dated 5/9/18, dated 2/13/18, for Trazadone t bedtime for insomnia and er. The report also included an 5, which directed the staff to p pattern the first seven days he time a day starting on the the 8th of every month for e recommendations of the consultant. Record the wake during the night, number ring the night, yes or no to s during the night-if yes, write a urs of stud will be 8:00 pm. to					
	nted on 5/9/18, indicated at rn disturbance due to					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
		00995	B. WING			0/2018
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NALKER	REHABILITATION &		HWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{21540}	Continued From pa	ige 27	{21540}			
	Trazadone for slee to administer the m physician and to as and to offer non-ph	disturbance and use of p. The plan directed the staff edication as ordered by the sess for adverse side effects armacological interventions , relaxation techniques, soft or				
		d lacked evidence of a sleep mentation having been				
	room, seated in his	p.m. R13 was observed in his electric wheelchair. When any sleep disturbances.				
	reviewed R13's clin	o.m. registered nurse (RN)-B lical record and stated she was y type of documentation attern study.	3			
	clinical services con lacked evidence of	om. the regional director of nfirmed R13's clinical record R13's sleep pattern and ttern study/documentation was ordered.				
	Region policy and p identified the facility comply with state a to the use of psych to include regular re appropriate dosage benefits. Additional of determining the	e Management Minnesota procedure dated 12/23/17, y would make every effort to nd federal regulations related opharmacological medications eview for continued need, e, side effect, risks and/or ly, the facility supports the goa underlying cause of behavioral ppropriate treatment of	1			
		cal, and/or behavioral ell as psychopharmacological be utilized.				

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	00995	B. WING		R 05/10/2018				
NAME OF PROVIDER OR SUPPLIEF	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE					
WALKER REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700					
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE				
Minnesota Department of Health								

DEDA	DTMENT	OF	UFALTU	AND	LITIMAN	SERVICES
DEPA	KINENI	Ur.	пеасти	AND	HUMAN	SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: R193

PA	RT I - TO BE COMPLETED BY THE ST	ATE SURVEY AGENCY Facility ID: 00995
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245323 2.STATE VENDOR OR MEDICAID NO.	3. NAME AND ADDRESS OF FACILITY (L3) WALKER REHABILITATION & F (L4) 209 BIRCHWOOD AVENUE WEST (L5) WALKER, MN	I Initial 2. Recertification S Termination 4. CHOW (L6) 56484 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 02/01/2017	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESR	02 (L7) D 13 PTIP 22 CLIA 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 03/27/2018 (L 8. ACCREDITATION STATUS:	34) 02 SNF/NF/Dual 06 PRTF 10 NF 0) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/ 04 SNF 08 OPT/SP 12 RHC	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 40 (L 13.Total Certified Beds		And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room * Code: B* (L12)
14. LTC CERTIFIED BED BREAKDOWN	Requirements and/or Applied waivers.	* Code: B * (L12) 15. FACILITY MEETS
	SNF ICF IID	1861 (e) (1) or 1861 (j) (1): (L15)
(L37) (L38) (l	.39) (L42) (L43)	
16. STATE SURVEY AGENCY REMARKS (IF APPL 17. SURVEYOR SIGNATURE	ICABLE SHOW LTC CANCELLATION DATE):	18. STATE SURVEY AGENCY APPROVAL Date:
Lisa Carey, HFE NE II	05/04/2018 (L19)	Douglas S. Larson, Enforcement Specialist 05/15/2018 (L20)
PART II - 7	O BE COMPLETED BY HCFA REGION	AL OFFICE OR SINGLE STATE AGENCY
 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible 	20. COMPLIANCE WITH CIVIL RIGHTS ACT: L21)	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above :
22. ORIGINAL DATE 23. LTC AG	GREEMENT 24. LTC AGREEMENT	26. TERMINATION ACTION: (L30)
OF PARTICIPATION BEGIN 07/01/1986	INING DATE ENDING DATE	VOLUNTARY 00 INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement
	RNATIVE SANCTIONS pension of Admissions:	03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change
(L27) B. Rese	(L44) ind Suspension Date: (L45)	00-Active
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS
	01111	
(L28)	(L31)	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE	
(L32)	(L33)	DETERMINATION APPROVAL



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically Submitted

April 17, 2018

Ms. Brooke Slaughter, Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West Po Box 700 Walker, MN 56484

RE: Project Number S5323027

Dear Ms. Slaughter:

On March 27, 2018, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies; <u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on March 27, 2018, that the conditions resulting in our notification of immediate **jeopardies** have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective April 22, 2018. (42 CFR 488.422)

Walker Rehabilitation & Healthcare Center April 17, 2018 Page 3

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiencies cited at F607, F686, F688, F689, F745 and F880. (42 CFR 488.430 through 488.444)

CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective March 27,2018

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June15, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 15, 2018.

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

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has

Walker Rehabilitation & Healthcare Center April 17, 2018 Page 4

been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Walker Rehabilitation & Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 27, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial

Walker Rehabilitation & Healthcare Center April 17, 2018 Page 6

compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 June 15, 2018, 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 September 27, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

Walker Rehabilitation & Healthcare Center April 17, 2018 Page 7

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		'		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			-	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245323	B. WING _		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted 3/19/18, recertification surve	iance with CMS Appendix Z edness Requirements, was through 3/27/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 00	00		
	Department of Hea	ucted by the Minnesota Ith on 3/19/18, through y resulted in an Immediate 89 and F880.				
	residents: - On 3/21/18, at 10: comprehensively as exit seeking behavi facility; - On 3/22/18, at 12: comprehensively as were being transfer unsafely; and - On 3/22/18, at 1:1 comprehensively as (R14) and impleme The IJ for F689 was	F689 for the following 01 a.m. related to failure to ssess residents (R226) with or and elopements from the 00 p.m. related to failure to ssess residents (R2, R8) who red via a mechanical lift 0 p.m. related to failure to ssess residents at risk for falls on consistent fall interventions. s removed on 3/27/18, at rification of a removal plan.				
	the facility's system appropriate infectio the transmission of of the facility was d had signs/symptom The IJ for F880 was 12:00 p.m. after ver	F880 on 3/23/18, related to ic failure to implement n control practices to prevent influenza A, when over 50% iagnosed with influenza and/or is of influenza. s removed on 3/27/18, at rification of an appropriate		TITLE		(X6) DATE

Electronically Signed

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.

04/26/2018

PRINTED: 05/04/2018

	-	AND HUMAN SERVICES & MEDICAID SERVICES		F	FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(3) DATE SURVEY COMPLETED
		245323	B. WING _		03/27/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	Continued From pa removal plan.	ge 1 / was conducted by the	F 00	0	
	Minnesota Departm through 3/27/18.	ent of Health on 3/23/18			
	signature is not requ				
F 558	revisit of your facility that substantial com has been attained in verification. Reasonable Accom	acceptable POC an on-site y will be conducted to validate apliance with the regulations in accordance with your modations Needs/Preferences	F 55	8	5/6/18
SS=D	services in the facili accommodation of preferences except endanger the health other residents.	ight to reside and receive ity with reasonable			
	Based on observat review, the facility fa accommodation of	ion, interview and document ailed to ensure reasonable need related to call lights f 2 residents (R14) with		This Plan of Correction constitutes m written allegation of compliance for th deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet	ne sion that
		rsing home admission 1/23/18, indicated R14 had		requirements established by state an federal law. 1. It is the policy of the facility to ens	

Facility ID: 00995

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PRINTED: 05/04/2018

					OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245323	B. WING		03/27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIC
F 558	Continued From pa	age 2	F 5	58	
	been admitted to the diagnoses that inclu- closed nondisplace cervical vertebra wi- pressure, type II dia advanced Alzheimed disturbance. The admission Min 1/26/18, indicated F impairment, suffer- fall prior to admissi- inappropriate behar limited assistance of ambulating in room assistance of one p extensive assistance and toilet use, and bowel and bladder. R14 was observed laying in bed in his had a cervical colla- to a thoracic lumba stabilizing brace that and abdomen. R14 (approximately 12 i there was fall mat p had not been provisi assistance.	in a facility on 1/19/18, and had uded, but were not limited to: ed fracture of the seventh ith routine healing, high blood abetes, late onset moderately er's disease with behavioral imum Data Set (MDS) dated R14 had moderate cognitive ed a fracture as a result of a on, not displayed any vior symptoms, required of one person when h, required extensive berson for transfers, required ce of one person for dressing was frequently incontinent of		 reasonable accommodations to a residents. One of the many ways has been achieved for resident #1 making sure resident has call ligh reach always when in room. Also, sure because of high risk for falls is checked on frequently to ensure safe and staff ask if he needs any from staff. Because all residents stay in facility and often sit in room by the or lay in bed all need to have acces their call light to be able to call for assistance, so all are potentially a by the cited deficiency. On 4/19/2 DON and SSC walked around and with staff and residents to make s needs were met and call light in reresidents have been rounded on the ensure call lights are available an being met. If a room was noted to have followed procedure, immedia correction was completed, and stareminded of the policy. The policy answer call lights has been review other residents will include interdisciplinary review with reside and/or family to ensure reasonabl accommodations are being met. To enhance currently complia operations and under the direction 	that this 4 is by t in to make resident e he is thing our emselves ess to ffected 018, the d visited ure each. All o d needs not ate aff were on ved. No arterly ent e nt
	wheelchair in his be facility staff stop int	hile seated up in the edroom. At no time did any to R14's room to check on R14 not have access to the call sistance.		DON, on 5/1/2018 all staff will rec in-service training regarding state federal requirements for reasonal accommodations and review the importance of aiding residents, ch	and ble ecking
		on 3/20/18, at 7:18 p.m.		on those that are fall risk, and hav resident able to reach call light alv	ring

Facility ID: 00995

If continuation sheet Page 3 of 250

						0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	245323 B. WI		B. WING		03/2	7/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 558	Continued From pa	ige 3	F 558	8		
	evening care and a to wear the TLSO, mat next to the bed call light to summor observations. On 3/21/18, at 9:00 the dining room and wheelchair and plac where he actively w R14 was not provid assistance. Review of R14's ca the following interve sure the resident's encourage the resident's encourage the resident's encourage the resident's all requests for ass The regional direct was interviewed reg during which she co been provided the o assistance and min The Superior Healt	or of clinical services (RDCS) garding R14's fall incidents onfirmed R14 should have call light to summon		Also, to remind resident to use call call for assistance and make sure r is functionally able to utilize call ligh 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision DON to monitor residents to ensure lights available. The DON or desig quality-assurance representative wi perform the following systematic ch audits of call light placement and ro to be completed on all shifts for all residents each week for 6 weeks, th 50% of residents each week audite call light placement and rounds on a shifts for 6 weeks. Any deficiencies corrected on the spot, and the findin the quality-assurance checks will be documented, submitted and monito the monthly quality-assurance com- meeting. 5. The DON will be responsible for POC.	esident t. of the e call nated ill anges: ounds hen d for all will be ngs of e ored at mittee	
F 576 SS=C	bed or confined to a within easy reach o Right to Forms of C	Communication w/ Privacy	F 570	6	Į	5/6/18
	reasonable access	resident has the right to have to the use of a telephone, TDD services, and a place in				

Facility ID: 00995

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION	(X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED
	OUNCOUNT	IDENTIFICATION NUMBER.	A. BUILDING			
		245323	B. WING			/27/2018
NAME OF PROVIDER OR SUPPLIER WALKER REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, Z		
				209 BIRCHWOOD AVENUE WES WALKER, MN 56484	ST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 576	Continued From pa	age 4	F 5	76		
	the facility where ca overheard. This inc	alls can be made without being cludes the right to retain and a at the resident's own				
	facilitate that reside individuals and ent facility, including re (i) A telephone, inc (ii) The internet, to facility; and	facility must protect and ent's right to communicate with ities within and external to the easonable access to: luding TTY and TDD services; the extent available to the tage, writing implements and nail.				
	and receive mail, a and other materials resident through a service, including the (i) Privacy of such with this section; and (ii) Access to station	communications consistent				
	reasonable access electronic communicati (i) If the access is a (ii) At the resident's expense is incurred access to the resid (iii) Such use must law.	comply with State and Federal				
	by: Based on observa	NT is not met as evidenced tion, interview and document failed to ensure resident mail		This Plan of Correction written allegation of com		

If continuation sheet Page 5 of 250

	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MILLI TU			<u>//B_NO.</u> (X3) DATE	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			9 BIRCHWOOD AVENUE WEST PO BOX 7 ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 576	Continued From pa	age 5	F 57	6			
		aturdays and reasonable	1 01	Ŭ.	deficiencies cited. However, submis	ssion	
		net was provided. This had the			of this Plan of Correction is not an		
		Il 23 residents residing in the			admission that a deficiency exists o	r that	
	facility.				one was cited correctly. This Plan	of	
					Correction is submitted to meet		
	Findings include:				requirements established by state a federal law.	ina	
	During the resident	council meeting held on			1. It is the policy of this facility to p	rovide	
		n. R17 and R13 both stated			opportunity for residents to have rig		
		nail was not being delivered on			forms of communication with privac		
	Saturdays.				this case R17 and R31stated they c		
					get their mail on Saturdays. In this of		
		a.m. nursing assistant (NA)-B lents' mail was not delivered			after the surveyor reported the fault		
		had not been for about the past			system, the administrator worked or plan that a staff member would go t		
	year.				post office every Saturday to get ma		
	5				post office box and staff would deliv		
		88 a.m. both the administrator			computer is now on site and connect		
		sing (DON) stated they were			for residents to utilize as they wish.	The	
		ents' personal mail was not			area also assures privacy for the		
		Saturdays. The administrator sign a staff member to begin			residents.2. Because all residents have the	right to	
		on Saturdays, as required.			communication with privacy, all are	ngni to	
	g				potentially affected by the cited defi	ciency.	
		roximately 9:00 a.m. both			On 4/18/2018, the ED reviewed this		
		ited they thought there was a			with leadership team at stand up an	nd all	
		sidents to use in the resident			will make efforts to ensure policy is		
	lounge room, "or a	least there used to be."			followed and mail is on site Saturda Since survey mail has been delivered		
	-At 10:33 a.m. the	administrator and DON stated			Saturdays and the computer is up a		
		computer in the lounge room			available for all residents. No other		
	for the residents to	use and upon observation of			residents were affected. The policy		
		d it was not there. Both stated			procedure for mail delivery was revi		
		nted a computer to use, they			and communication policy regarding	g	
	could put a comput	er in the activity room.			computer use was developed.3. To enhance currently compliant		
	Superior Healthcar	e Management Resident Mail			operations and under the direction of		
		re dated 12/23/17, indicated			DON, on 5/1/2018 all staff will recei		
		I have the opportunity to stay			in-service training regarding mail de		

Facility ID: 00995

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI T		D. 0938-039 ATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	· /		MPLETED
		245323	B. WING _	03	3/27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WALKEF	REHABILITATION 8	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 576	in contact with fam mail services. The mail delivery servic within 24 hours of request to send ma	ily/friends/community through Living Center would provide ces and mail sending services receipt of mail or residents ail. This includes Saturdays ole access to electronic mail	F 57	 and computers for resident. The training will emphasize the importance of ensurin all residents have ability to get outside communications and send mail to others as well as expectations of residents and computer use. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the ED to monitor resident mail delivery and verify computer is properly working for residents. ED or activities will also speak with residents regarding use and policy a next resident council. Audits will be completed weekly for 8 weeks to assure compliance. Any deficiencies will be documented and submitted at the monthl quality-assurance committee meeting for further review or corrective action. 5. ED and activities POC. 	g s t y
F 607 SS=F	CFR(s): 483.12(b) §483.12(b) The fac	cility must develop and	F 60	•	5/6/18
	•	policies and procedures that:			
	neglect, and explo	hibit and prevent abuse, itation of residents and f resident property,			
		ablish policies and procedures such allegations, and			
	§483.12(b)(3) Inclu paragraph §483.95	ude training as required at 5.			

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTI	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	G		PLETED
		245323	23 B. WING 03/2		27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 607	Continued From pa	age 7	F 60 ⁻	7		
		NT is not met as evidenced				
	facility failed to dew procedures related abuse/neglect and misappropriation of the facility lacked p identification, prote investigating reside elopement, and inju of 4 residents (R13 who had a resident elopement, or an ir was not reported, in protection was not were not developed failure had the pote residing in the facil Findings include: On 3/20/18 at 1:41 review the facility a procedures, the ad nursing (DON) stat it within the facility.	p.m. when requested to buse prevention policy and ministrator and director of ed they were unable to locate		This Plan of Correction constitut written allegation of compliance deficiencies cited. However, sub of this Plan of Correction is not a admission that a deficiency exist one was cited correctly. This Pla Correction is submitted to meet requirements established by stat federal law. 1. It is the policy of this facility for on any incident that result in inju case R13 and R21 were noted to history of not getting along and la altercation which was not address management, incident reporting, interventions or reported as requ R226 had eloped from facility co times and last time was returned police; incident was not reported agency as required. R5 had brui unknown origin and no investiga been completed nor any report r this case, after the surveyor repo faulty system, the policy and pro abuse/neglect and reporting had reviewed and updated. All staff w	for the mission an an of an of a and a or that an of a and a or report ollow up ry. In this o have a ed to an ased with uired. uple I via to state se of tion had nade. In orted the cedure on been	
	clinical services (R been with the facilit three weeks and th facility. At this time Superior Healthcar executive who over executive stated th of the facility on 2/2	DCS) stated she had only ty's management company for is was her first time at the e, the RDCS called the e Management (SHM) rseen this facility. The e company took over operation I/17, whereas there was a who continued to work at the		in-serviced, and information put station in case staff need clarific while survey was still in process, and SSC were also educated on importance of reporting all vulne adult cases to the OHFC (office facility complaints). All incidents accidents are to be reviewed imi- for any potential abuse or negled	at nursing ation Nursing rable of health and mediately	

Facility ID: 00995

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		& MEDICAID SERVICES	(X2) MUI	TIPI			0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	· ·				PLETED
		245323	B. WING			03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 70 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 607	Continued From pa	ae 8	F 6	07			
	which ended June 3 started working at t for overseeing the o November 2017. Fo departure, there wa assigned to this "pr supervisor was not available for consul RDCS verified and facility systems and binder to place the program policy and staff education. On 3/22/18, the RD Healthcare Manage Investigation policy corporate website a indicated the facility and other licensing circumstances of th compliance with Fe and Elder Justice A Facility Manageme indicated it was the employees to prom suspected incident including injuries of misappropriation of management. The immediately notified incidents of abuse. Resident Altercation form indicated all a represent resident treported to the nurs the administrator. T	2017, at which time a RDCS he facility and was responsible clinical nursing operation until ollowing this employees as no specific regional director operty" therefore a clinical present on site, rather was ltation via the phone. The acknowledged the lack of d stated she would create a facility abuse prevention procedures in and provide OCS provided a Superior ement Abuse Reporting and which was printed from the and was revised 1/30/17, / would notify the State agency agencies depending on the ne allegation or actual event in ederal and State regulations act. The Reporting Abuse to int policy and procedure responsibility of their ptly report any incident or of neglect or resident abuse, f unknown source, and theft or f resident property to facility administrator or DON must be d of suspected abuse or actual The undated Resident to ins policy and implementation ltercations including those that to resident abuse would be sing supervisor, DON and to The undated Elopement policy mplementation form indicated	ΓŬ	07	 was created, put at nursing stations educated to all staff to ensure the components of abuse and neglect a identified and immediately followed 2. Because all residents receiving physical assistance are potentially affected by the cited deficiency and residents are considered vulnerable are potentially affected to potential f abuse/neglect. All incidents have sin been investigated and reported accordingly. Since survey all incide and accidents are reviewed, and an resident sustaining injury has been reviewed and reported immediately. other residents were affected. The p and procedure for abuse/neglect wareviewed and updated. 3. To enhance currently compliant operations and under the direction of DON, on 5/1/2018 all staff will receive in-service training regarding minimizaccidents. The training will emphase importance of taking all statements resident leaving seriously to prevent elopement, investigating all bruises skin tears, and separating resident is altercation occurs and immediately notifying DON and ED of any of the previously mentioned incidents. Also reviewed abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s and resident protection manual. Stated abuse/neglect policy and s	are up on. all all or nce nts y No policy as of the ve zing size the of t and if o safety, aff s of	

Facility ID: 00995

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245323	B. WING _		03/	27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484	OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 607	Continued From pa	age 9	F 60	70		
	Minnesota Region A policy and procedu implementation prive website indicated of procedures had be in preventing abuse the residents. Their provided policies at as a minimum: -identification of oc potential abuse/mis -protection of resid investigations -the development of -timely and thoroug and allegations of a -the reporting and f related to incidents -ongoing review an and -the implementation occurrences of abu R13 stated during i a.m. that R21 used currently lived a co he could not get allo would threaten to " being just two days months ago, when with staff present, F punched him in the being injured. R13 witnessed the incid down." R13 denied stated, "all he is, is	ents during abuse of investigative protocols h investigations of all reports abuse illing of accurate docents of abuse d analysis of abuse incidents, n of changes to prevent further		and accidents to ensure followi All incidents, accidents and inju reviewed to ensure follow up co per resident protection manual investigation log. The DON or quality-assurance representativ perform the following systemat the DON in conjunction with SS make report immediately if any abuse/neglect or injury was sus incidents/accidents or suspects abuse/neglect situations will be daily during the week at stand to DON or designee will complete all reported incidents on reside weeks then 50% of incidents for to ensure compliance in this art deficiencies will be corrected of and the findings of the quality-a checks will be documented, su and monitored at the monthly quality-assurance committee m further review or corrective acti 5. ED, DON will be responsib POC.	ries will be ompleted and designated e will c changes: C will pected. All d reviewed up. The audits of nts for 8 r 8 weeks ea. Any n the spot, ssurance omitted eeting for on.	

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	-	AND HUMAN SERVICES			FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245323	B. WING		03/:	27/2018
NAME OF 1	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 607	Continued From pa	ge 10	F 607			
	stated R21 and R13 did not get along an so they got separat currently, when R13 room, R21 would ca approximately four staff member who s member it was, had go up to R13 and p stated as staff were R13 had called R21 this physical alterca was aware of betwe also stated she had nurse but was not 1 had reported to. Th aforementioned res was reported to the agency within 2 hou or protection provid incident as well as 1 R226 eloped from t facility's computeriz list. The note indica within the facility so search was conduc locating R226 and 9 called, they informer resident was at the police returned the unharmed. The faci facility Minnesota In Management List w 7:30 a.m. which ind the facility and a ter	p.m. nursing assistant (NA)-B 3 used to be roommates who of would swear at each other e rooms. NA-B stated 3 would wheel past R21's all R13 names. NA-B stated months ago, she and another she could not recall which staff d witnessed R21 intentionally unch him in the arm. NA-B e moving R13 away from R21, 1 the "F-word." NA-B stated ation was the only incident she een the two residents. NA-B d reported the altercation to a 100% sure which nurse she e facility lacked evidence the sident to resident altercation e administrator or the State urs as required, investigated ded to R13 following the the verbal abuse by R21. The facility according to the eed Risk Management Incident ted R226 could not be located of a building and grounds ted which was unsuccessful in 911 was called. When 911 was ed the facility their missing local police department. The resident to the facility, ility provided a copy of their noident Report from the Risk which was dated 12/3/17, at licated R226 had eloped from mporary wanderguard was 15 minute checks were				

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	' 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	initiated. However, administrator or Sta elopement within 24 investigation condu On 3/20/18, at 6:30 was not happy abore eloped from the face stated the incident we was not the only tim attempted to leave another incident wh police department i to go pick up R226 and was downtown across from the pol "somebody" had can the staff that one of however, that "som back to the facility to C-A stated R226 us have had to get dow down the middle of area of the road that following the snow being appropriately temperature. R226' evidence of this prid documentation indir reported to the adm within 24 hours, not conducted in order interventions to ens R5's Progress Note indicated R5 had a bruise which was y pinkness surroundi	it lacked evidence the age agency was notified of the 4 hours, nor was a thorough acted. p.m. cook (C)-A stated R226 ut being at the facility and had cility a couple of times. C-A with the police department ne R226 had gotten away or the facility. C-A recalled nich occurred "way" before the incident, where he was going after he had left the facility at a gas station which was lice department. C-A stated alled the facility and informed f their residents was there, nebody" had given R226 a ride before he could go get him. Sed a wheelchair and would wntown by wheeling himself the street as that was the only at had been plowed open fall. C-A remembered R226 dressed for the cold winter 's medical record lacked or elopement as well as cating the incident had been ninistrator or State agency r was a thorough investigation to identify and implement sure R226's ongoing safety.	F	607			

Facility ID: 00995

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	-	AND HUMAN SERVICES				FORMA	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE	
		245323	B. WING _			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WI WALKER, MN 56484	EST PO BOX 7	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE!	CTION SHOULD O THE APPROPR	BE	(X5) COMPLETION DATE
F 607	was located on R5. A Resident Bruise/S 3/13/18, indicated F bruise on the right f caused by an arm b and director of nurs However, the State 24 hours, nor was a conducted in order On 3/20/18 at 1:41 review the facility al procedures, the add they were unable to -At 1:49 p.m. the add confirmed R13's an The administrator, to informed of the alte were unaware the a confirmed it should administrator as we required. On 3/20/18, at 4:25 and the DON confir the facility and the i When asked about program related to the whole system n administrator stated	Skin Tear/ Injury Report dated R5 had a 6.0 cm by 3.0 cm forearm which may have been brace. R5's physician, family ses were notified of the bruise. Agency was not notified within a thorough investigation to rule out potential abuse. p.m. when requested to buse prevention policy and ministrator and DON stated	F 60	07			
	failure in the system the staff on the abu policies and proced On 3/26/18, at 3:26	n and had begun educating use prevention program					

		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		. 0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` '			IPLETED	
		245323	B. WING _		03/	27/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 607	Continued From pa	ge 13	F 60	17			
	facility abuse preve "Tuesday" (six days was kept at the nur facility's policy and prohibition in which needed. However, if any changes had	ntion program binder last prior) and verified the binder ses station and contained the procedures related to abuse staff were to refer to when LPN-A stated she did not know been made to the facility's ause she had not reviewed the					
F 609 SS=D			F 60	9		5/6/18	
	neglect, exploitation must:	n, or mistreatment, the facility					
	involving abuse, ne mistreatment, inclu source and misapp are reported immed hours after the alled that cause the alled serious bodily injury the events that cau abuse and do not re the administrator of officials (including to adult protective ser for jurisdiction in log	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in γ , or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established					
	designated represe accordance with St	ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the					

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI TI	PLE CONSTRUCTION	OMB NO.	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED	
		245323	B. WING _		03/	27/2018	
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
VALKEF	R REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST WALKER, MN 56484		Г PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 609	Continued From pa	age 14	F 60	9			
	· ·	alleged violation is verified					
		ive action must be taken.					
	This REQUIREME	NT is not met as evidenced					
	by:						
		v, and document review, the		This Plan of Correction consti			
		ure all allegations of abuse, l injuries of unknown source		written allegation of complianc deficiencies cited. However, su			
; ; ;		ly to the administrator and/or		of this Plan of Correction is no			
		of 1 resident (R13) who was		admission that a deficiency ex			
		another resident, and for 1 of 1		one was cited correctly. This I			
		o had eloped from the facility,		Correction is submitted to mee			
		he facility failed to report		requirements established by s	ate and		
		source to the State agency		federal law.			
		R5) who was found to have a		1. It is the policy of this facilit			
	leit lorearm bruise	of unknown source.		all incidents and do timely follo any incident that results in inju			
	Findings include:			case R13 and R21 were noted			
	r mango molado.			history of not getting along and			
	R13 stated during i	nterview on 3/19/18, at 9:24		altercation which was not addr			
	a.m. that R21 used	to be his roommate and		management, incident reportir			
		uple doors from him, however,		interventions or reported as re			
		ong with R21. R13 stated R21		R226 had eloped from facility			
		beat him up" most recently		times and last time was return			
		ago. R13 stated about two he was by the nursing station		police □ incident was not repo agency as required. R5 had br			
		R21 had "rolled up and		unknown origin and no investig			
		left shoulder." R13 denied		been completed nor any repor			
		stated the staff who had		this case, after the surveyor re			
	witnessed the incid	ent told R21 he had to "settle		faulty system, the policy and p	rocedure on		
		being afraid of R21 and stated		abuse/neglect and reporting ha			
		mouth" and that he tried to		reviewed and updated. All staf			
	stay away from R2	1 as much as he could.		in-serviced, and information pu	-		
	On 3/20/18 at 1.10	p.m. nursing assistant (NA)-B		station in case staff need clarif while survey was still in proces			
		3 used to be roommates who		and social service coordinator			
		nd would swear at each other		educated on importance of rep			
		te rooms. NA-B stated		vulnerable adult cases to the C			
	currently, when R1	3 would wheel past R21's		(office of health facility compla	ints).		
	room P21 would o	all R13 names. NA-B stated		2. All residents are potentially	(offeeted		

Facility ID: 00995

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245323	B. WING	i		03/2	27/2018
NAME OF PROVIDER OR SUPPLIER	·		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
staff member who member it was, hai go up to R13 and p stated as staff were R13 had called R2 this physical alterca was aware of betw also stated she had nurse but was not had reported to. Th aforementioned res was reported to the agency, within two R226 eloped from facility's computer list. The note indica within the facility so search was conduc locating R226 and called, they informed resident was at the police returned the unharmed. The fac facility Minnesota II Management List w 7:30 a.m. and revis R226 had eloped fit temporary wandero 15 minute checks w lacked evidence th On 3/20/18, at 6:30 was not happy abo eloped from the fac stated the incident was not the only tir	months ago, she and another she could not recall which staff d witnessed R21 intentionally bunch him in the arm. NA-B e moving R13 away from R21, 1 the "F-word." NA-B stated ation was the only incident she een the two residents. NA-B d reported the altercation to a 100% sure which nurse she he facility lacked evidence the sident to resident altercation a administrator or the State	F	609	by the cited deficiency and lack of f through. A new resident protection was created to educate staff on components of the abuse program program further educates staff on v report and what to report to ensure this type of situation does not occur The program also has an incident r guide to assist staff to determine w reportable and who to notify when. discussed was the proper procedur incident and accidents and the noti process to ensure DON is aware of situation for immediate follow up. P and procedure for abuse/neglect lis content for reportable events was reviewed. No other residents were affected. 3. To enhance currently complian operations and under the direction DON, on 5/1/2018 all staff will rece in-service training regarding require for investigating, preventing and co handling all incidents and accidents will also be advised with every incid regardless of how small or if no inju DON needs to be informed as well doctor, family/POA and documente accordingly in point click care. This reviewed daily during the week at s up with interdisciplinary team. Any deficiencies will be corrected on the documentation reviewed to include up nurse s notes, and appropriate notification made to POA, MD, DOI ED and OHFC if appropriate via DO SSC or ED. 4. Effective 4/18/2018, a quality-assurance program was	manual The when to that r again. report hat is Further re for fication f any olicy sting t of the ive ements rrectly s. Staff dent ury the as d will be tand e spot, follow N, also	

Facility ID: 00995

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		(X3) DATE	
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	PLETED
		245323	B. WING			03/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484			3OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 609	Continued From pa	ge 16	F 6	09			
	police department i to go pick up R226 and was downtown across from the pol "somebody" had ca the staff that one of however, that "som back to the facility b C-A stated R226 us have had to get dow down the middle of area of the road tha following the snow to being appropriately temperature. R226' evidence of this prid documentation india reported to the adm R5's Progress Note indicated R5 had a bruise which was y pinkness surroundii documentation did was located on R5. Set (MDS) dated 1/ cognitive impairmen activities of daily live A Resident Bruise/S 3/13/18, indicated F bruise on the right f caused by an arm b and director of nurs	ich occurred "way" before the ncident, where he was going after he had left the facility at a gas station which was ice department. C-A stated illed the facility and informed their residents was there, ebody" had given R226 a ride before he could go get him. Sed a wheelchair and would wntown by wheeling himself the street as that was the only at had been plowed open fall. C-A remembered R226 dressed for the cold winter s medical record lacked or elopement as well as cating the incident had been ninistrator or State agency. e dated 3/13/18, at 11:20 p.m. 6.0 centimeter (cm) by 3.0 cm rellow/green in color with some ng the bruise. The not identify where the bruise The quarterly Minimum Data 10/18, indicated severe nt, total assistance with ing and no resistance to cares. Skin Tear/ Injury Report dated R5 had a 6.0 cm by 3.0 cm forearm which may have been prace. R5's physician, family ses were notified of the bruise. Agency was not notified within at of the bruise of unknown			implemented under the supervision DON and ED to monitor all incident ensure anyone with injury or suspect abuse is reported immediately to Of All incidents, accidents and injuries reviewed to ensure follow up compli- per resident protection manual and investigation log. The DON or desig- quality-assurance representative wi- perform the following systematic ch- the DON in conjunction with SSC wi- make report immediately if any abuse/neglect or injury was suspect incidents/accidents or suspected abuse/neglect situations will be revi- daily during the week at stand up. T DON or designee will complete aud all reported incidents on residents for weeks then 50% of incidents for 8 v to ensure compliance in this area. A deficiencies will be corrected on the and the findings of the quality-assur checks will be documented, submitt and monitored at the monthly quality-assurance committee meetin further review or corrective action. 5. DON, ED and SSC will be respon- for this POC.	s to cted HFC. will be eted gnated II anges: ill ted. All ewed The its of or 8 veeks Any e spot, rance ted ng for	

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	review the facility all procedures, the add nursing (DON) state it within the facility. -At 1:49 p.m. the add confirmed R13's and The administrator, the director of clinical s informed of the alter were unaware the add confirmed it should administrator as we required. On 3/20/18, at 4:25 RDCS, and the DO from the facility and When asked about program related to the whole system in administrator stated started at the facility failure in the system the staff on the abu policies and proced On 3/21/18, at 8:40 had only been with company for three w time at the facility. the Superior Health executive who over executive stated the of the facility on 2/1 former employee w facility through the o	p.m. when requested to buse prevention policy and ministrator and director of ed they were unable to locate dministrator and the DON nd R21's dislike for each other. the DON and the regional services (RDCS) were ercation and all stated they altercation had occurred and have been reported to the ell as the State agency, as 5 p.m. the administrator, N confirmed R226 had eloped d the incident was not reported. the facility's abuse prevention reporting, the RDCS stated needed to be "revamped." The d when her and the DON y, they became aware of the n and had begun educating use prevention program	F 60	09			

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STATEMEN	F OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
		245323	B. WING	NG			
NAME OF	PROVIDER OR SUPPLIER	240020	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	03	8/27/2018	
		HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 609	started working at t for overseeing the o November 2017. Fe departure, there wa assigned to this "pr supervisor was not available for consul RDCS verified and facility systems and binder to place the program policy and staff education. On 3/26/18, at 3:26 (LPN)-A stated she facility abuse preve "Tuesday" (six days was kept at the nur facility's policy and prohibition in which needed. However, if any changes had abuse protocol bec information yet. On 3/22/18, the RD Healthcare Manage Investigation policy facility would notify licensing agencies circumstances of th compliance with Fe and Elder Justice A Facility Manageme indicated it was the employees to prom suspected incident including injuries of	the facility and was responsible clinical nursing operation until ollowing this employee's as no specific regional director operty" therefore a clinical present on site, rather was ltation via the phone. The acknowledged the lack of d stated she would create a facility abuse prevention l procedures in and provide 6 p.m. licensed practical nurse was shown the newly created ention program binder last s prior) and verified the binder ses station and contained the procedures related to abuse staff were to refer to when LPN-A stated she did not know been made to the facility's ause she had not reviewed the DCS provided a Superior ement Abuse Reporting and revised 1/30/17, indicated the the State agency and other	F 6	09			

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI 1	TIPLE CONSTRUCTION		. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	· /	NG		IPLETED
		245323	B. WING		03/	27/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	. 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 609	Continued From pa	ge 19	F 6	09		
	management. The immediately notified incidents of abuse. Resident Altercation form indicated all al represent resident to reported to the nurs the administrator. T interpretation and in	administrator or DON must be d of suspected abuse or actual The undated Resident to ns policy and implementation Itercations including those that to resident abuse would be sing supervisor, DON and to The undated Elopements policy mplementation form indicated Il cases of missing residents,				
F 610 SS=D	CFR(s): 483.12(c)(§483.12(c) In respo	/Correct Alleged Violation 2)-(4) onse to allegations of abuse, n, or mistreatment, the facility	F 6	10		5/6/18
		e evidence that all alleged ughly investigated.				
		ent further potential abuse, n, or mistreatment while the rogress.				
	designated represe accordance with St Survey Agency, with incident, and if the appropriate correct	ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced				
	Based on interview facility failed to con- allegations of poter injuries of unknown	v, and document review, the duct an investigation of itial abuse, neglect of care and source for 1 of 1 resident n intentionally hit by another		This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, submo of this Plan of Correction is not an admission that a deficiency exists	or the nission n	

Facility ID: 00995

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
		IDENTIFICATION NOMBER.	A. BUILDIN	IG _		COM		
		245323	B. WING			03/2	27/2018	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 610	Continued From pa	ae 20	F 61	0				
	resident,; for 1 of 1 eloped from the fac resident (R5) who h unknown source. Findings include: R13 stated during i a.m. that R21 used currently lived a con he could not get ald would threaten to "H being just two days months ago, when with staff present, F punched him in the being injured. R13 witnessed the incid down." R13 denied stated, "all he is, is tried to stay away fi On 3/20/18, at 1:10 stated R21 and R13 did not get along ar so they got separat currently, when R13	resident (R226) who had sility, twice; and for 1 of 1 had forearm bruising of nterview on 3/19/18, at 9:24 to be his roommate and uple doors from him, however, ong with R21. R13 stated R21 beat him up" most recently ago. R13 stated about two he was by the nursing station R21 had "rolled up and left shoulder." R13 denied stated the staff who had ent told R21 he had to "settle being afraid of R21 and one big mouth" and that he form R21 as much as he could. p.m. nursing assistant (NA)-B 3 used to be roommates who nd would swear at each other e rooms. NA-B stated 3 would wheel past R21's all R13 names. NA-B stated			one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of this facility to investigate, prevent and correct alle violations of residents. In this case case R13 was been punched in an altercation which was not addresse management, no incident reporting nor interventions taken or reported required. R226 had eloped from fac couple times and last time was retu- via police; incident was not reported state agency as required. R5 had bu of unknown origin and no investigat had been completed nor any report In this case, after the surveyor report the faulty system, the policy and procedure on abuse/neglect and rep- had been reviewed and updated. Al- were in-serviced, and information p nursing station in case staff need clarification while survey was still in process. Nursing and SSC were alse educated on importance of investiga- all incident and reporting all vulnera adult cases to the OHFC (office of the state agent of the other of the other of the other other other other adult cases to the OHFC (office of the other ot	and eged in this d with done, as cility rned d to ruise cion made. orted porting Il staff ut at so ating ible		
	approximately four staff member who s member it was, had go up to R13 and p stated as staff were R13 had called R22	months ago, she and another she could not recall which staff d witnessed R21 intentionally unch him in the arm. NA-B e moving R13 away from R21, 1 the "F-word." NA-B stated			 facility complaints). Because all residents are poten affected by the cited deficiency and follow through, while survey still was conducted, ED and DON reviewed staff the importance of investigating 	ntially lack of s being with all g and		
	was aware of betwee also stated she had nurse but was not 1	ation was the only incident she een the two residents. NA-B I reported the altercation to a 100% sure which nurse she 3's and R21's medical record			reporting suspected violations. A neresident protection manual was created ucate staff on components of the program. The program further educated staff on what should be investigated.	ated to abuse ates		

Facility ID: 00995

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II -	יפוד	LE CONSTRUCTION		0938-039	
	D PLAN OF CORRECTION IDENTIFICATION NUMBER: 245323		· ·			(X3) DATE SURVEY COMPLETED		
			B. WING			03/2	27/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
VALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 3 VALKER, MN 56484	700	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 610	Continued From pa	ige 21	F 6	10				
	thoroughly investiga R226 eloped from t	e altercation occurred and was ated. the facility according to the zed Risk Management Incident			is abuse/neglect and determining r cause of incident, when to report a to report to ensure that this type of situation does not occur again. The program also has an incident report	nd what e		
	list. The note indica within the facility so search was conduc	a building and grounds ted which was unsuccessful in 911 was called. When 911 was			to assist staff to determine what is reportable and who to notify when. discussed was the proper procedu incident and accidents and the not	Further re for		
	called, they informer resident was at the police returned the	ed the facility their missing local police department. The resident to the facility, ility provided a copy of their			process to ensure DON and ED ar aware of any situation for immedia follow up. Policy and procedure for abuse/neglect was reviewed. No o	te		
	facility Minnesota Ir Management List w 7:30 a.m. which ind	ncident Report from the Risk which was dated 12/3/17, at licated R226 had eloped from			 residents were affected. 3. To enhance currently complian operations and under the direction DON, on 5/1/2018 all staff will receipted to the staff will	it of the		
	placed, and every 1 initiated. However,	mporary wanderguard was I5 minute checks were there was no indication the horoughly investigated.			in-service training regarding require for investigating, preventing and co handling all incidents and accident will also be advised with every incident	ements orrectly s. Staff		
	was not happy about eloped from the factorial sectors and the factors and the factors and the factors and the factors are the factors and the factors are the	p.m. cook (C)-A stated R226 ut being at the facility and had sility a couple of times. C-A with the police department			regardless of how small or if no inji DON needs to be informed as well doctor, family/POA and documente accordingly in point click care. This	ury the as ed		
	was not the only tin attempted to leave another incident wh	ne R226 had gotten away or the facility. C-A recalled nich occurred "way" before the			reviewed daily during the week at s up with interdisciplinary team. Any deficiencies will be corrected on th	stand , e spot,		
	to go pick up R226 and was downtown	ncident, where he was going after he had left the facility at a gas station which was lice department. C-A stated			documentation reviewed to include up nurse⊡s notes, and appropriate notification made to POA, MD, DO ED and OHFC if appropriate via D	e N, also		
	"somebody" had ca the staff that one of however, that "som	lled the facility and informed f their residents was there, ebody" had given R226 a ride			SSC or ED. 4. Effective 4/18/2018, a quality-assurance program was			
	C-A stated R226 us	before he could go get him. sed a wheelchair and would wntown by wheeling himself			implemented under the supervision DON and ED to monitor all inciden ensure anyone with injury or suspe- abuse is reported immediately to C	ts to		

Facility ID: 00995

	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATI	0938-039		
	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	3		COMPLETED		
245323		B. WING		03/27/2018				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD				
WALKER REHABILITATION & HEALTHCARE CENTER				209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE		
F 610	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		F 610	All incidents, accidents and injreviewed to ensure follow up of per resident protection manual investigation log. The DON of quality-assurance representat perform the following systema the DON in conjunction with S make report immediately if an abuse/neglect or injury was su incidents/accidents or suspect abuse/neglect situations will b daily during the week at stand DON or designee will complet all reported incidents on reside weeks then 50% of incidents for ensure compliance in this a deficiencies will be corrected of and the findings of the quality-checks will be documented, su and monitored at the monthly quality-assurance committee refurther review or corrective ac 5. DON, ED and SSC will be for this POC.	completed I and designated ive will tic changes: SC will y Ispected. All e reviewed up. The e audits of ents for 8 or 8 weeks rea. Any on the spot, assurance ubmitted meeting for tion.			
	nursing (DON) stat it. -At 1:49 p.m. the au confirmed R13's ar The administrator, director of clinical s	ministrator and director of ed they were unable to locate dministrator and the DON nd R21's dislike for each other. the DON and the regional services (RDCS) were ercation and all stated they						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING	;		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	Continued From pa investigation.	ige 23	F	610			
	RDCS, and the DO from the facility and When asked about program related to the whole system n administrator stated started at the facility failure in the system	5 p.m. the administrator, N confirmed R226 had eloped d the incident was not reported. the facility's abuse prevention investigation, the RDCS stated needed to be "revamped." The d when her and the DON y, they became aware of the n and had begun educating use prevention program dures.					
	had only been with company for three with company for three with the Superior Health executive who over executive stated the of the facility on 2/1 former employee with facility through the of which ended June 2 started working at the for overseeing the of November 2017. For departure, there was assigned to this "pro- supervisor was not available for consul RDCS verified and facility systems and binder to place the program policy and staff education.	a.m. the RDCS stated she the facility's management weeks and this was her first At this time, the RDCS called neare Management (SHM) resen this facility. The e company took over operation 1/17, whereas there was a who continued to work at the ownership transition phase 2017, at which time a RDCS the facility and was responsible clinical nursing operation until ollowing this employee's as no specific regional director roperty" therefore a clinical present on site, rather was Itation via the phone. The acknowledged the lack of d stated she would create a facility abuse prevention I procedures in and provide					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			E SURVEY	
			A. BUILDING				
	IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	27/2018	
WALKER REHABILITATION & HEALTHCARE CENTER				209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 610 F 636 SS=D	(LPN)-A stated she facility abuse preve "Tuesday" (six days was kept at the nur- facility's policy and prohibition in which needed. However, I if any changes had abuse protocol bec- information yet. On 3/22/18, the RD Healthcare Manage Investigation policy indicated the facility all reports of suspe exploitation or injuri Resident to Reside implementation forr including those that abuse would be inv Elopements policy i implementation forr investigate all case Comprehensive As CFR(s): 483.20(b)(§483.20 Resident A The facility must co a comprehensive, a reproducible assess functional capacity. §483.20(b) Compre §483.20(b)(1) Resident A facility must make assessment of a re	was shown the newly created ntion program binder last s prior) and verified the binder ses station and contained the procedures related to abuse staff were to refer to when LPN-A stated she did not know been made to the facility's ause she had not reviewed the CS provided a Superior ement Abuse Reporting and revised 1/30/17, which would thoroughly investigate cted or alleged abuse, neglect, ies of unknown origin. The nt Altercations policy and m indicated all altercations crepresent resident to resident estigated. The undated interpretation and m indicated staff would s of missing residents sessments & Timing 1)(2)(i)(iii) Assessment induct initially and periodically accurate, standardized sment of each resident's	F 6'			5/6/18	

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		AND HUMAN SERVICES				FORM	D: 05/04/201 MAPPROVE D. 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
245323		B. WING	i		03/27/2018		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CC	•	
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PC) BOX 700	
					WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 636	Continued From pa	age 25	F6	536	6		
	the following: (i) Identification and (ii) Customary routi (iii) Cognitive patter (iv) Communication (v) Vision. (v) Nood and beha (vii) Psychological v (viii) Physical functi (ix) Continence. (x) Disease diagno (xi) Dental and nuti (xii) Skin Condition (xiii) Activity pursuit (xiv) Medications.	rns. n. avior patterns. well-being. ioning and structural problems. sis and health conditions. ritional status. s.					
	(xvi) Discharge pla (xvii) Documentation regarding the addition on the care areas to the Minimum Data (xviii) Documentation assessment. The a include direct observit the resident, a	nning. on of summary information ional assessment performed riggered by the completion of Set (MDS). on of participation in assessment process must rvation and communication s well as communication with censed direct care staff					
	timeframes prescri chapter, a facility m assessment of a re timeframes specifie through (iii) of this	en required. Subject to the bed in §413.343(b) of this nust conduct a comprehensive esident in accordance with the ed in paragraphs (b)(2)(i) section. The timeframes .343(b) of this chapter do not					

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PRINTED: 05/04/2018

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245323		B. WING		•	27/2018
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	
WALKER REHABILITATION & HEALTHCARE CENTER				209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484	°O BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 636	Continued From pa	age 26	F 6	36		
	(i) Within 14 calend	dar days after admission,				
	excluding readmiss	sions in which there is no				
		in the resident's physical or				
		For purposes of this section,				
		ns a return to the facility ary absence for hospitalization				
	or therapeutic leave					
		ice every 12 months.				
		NT is not met as evidenced				
	by:					
	Based on interview and document review, the facility failed to ensure Care Area Assessments were completed for 2 of 12 residents (R13, R14)			This Plan of Correction constit		
				written allegation of compliance		
		and/or significant change		deficiencies cited. However, su of this Plan of Correction is not		
	Minimum Data Set			admission that a deficiency exi		
		·		one was cited correctly. This F		
	Findings include:			Correction is submitted to mee		
				requirements established by st	ate and	
	R13's annual Minimum Data Set (MDS) dated 7/24/17, indicated R13 had moderate cognitive impairment, required limited to physical staff			federal law.		
				 It is the policy of this facility all residents are assessed corr 		
		vities of daily living, urinary		assessments and MDS to coor		
		atural or fragmented teeth and		appropriate care plans. Some		
		sure ulcers. The Care Area		many ways that this has been a		
		nary (CAA) indicated the		for R13 and R14 has been to h		
		re identified as needing further		nurse reopen and complete CA		
		sessment/investigation to		regarding their care needs bas		
	planning:	equired interventions and care		assessments. In this case, after surveyor reported all residents		
	Promining.			above the care area assessme		
	Cognitive/Loss Fur	iction		incomplete based on full review		
	Activity of Daily Liv	ing/Rehabilitation Potential		for these residents MDS s. Th	e care	
	Urinary Incontinend	ce		plans have been reviewed and		
	Falls			MDS nurse has reviewed prop		
	Nutritional Status Dental Care			completion of CAA guidelines a aware of how to properly docur		
	Pressure Ulcer			CAA s.		
				2. Because all residents are a	assessed to	
						1

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		& MEDICAID SERVICES			OMB NO.		
	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245323			IPLE CONSTRUCTION		ATE SURVEY OMPLETED	
			B. WING			27/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
NALKER	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	O BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 636	Continued From pa	ge 27	F 63	36			
	of the completion of On 3/22/18, at 1:25 stated she was resp assessments and the confirmed R13's 7/2 not completed, as r During interview with director of nursing (a.m. the administrat that the CAAs be conditioned R14's admission M R14 had moderate a fracture as a result no inappropriate be limited assistance of ambulating in room assistance of one p required extensive dressing and toilet having books or ne around animals or p religious activities v R14. Review of R14's un revealed the CAA he was no assessmen activity interests pri environmental or st participation, unique	f the identified CAAs. p.m. registered nurse (RN)-E ponsible to complete the MDS he corresponding CAAs. RN-E 24/17, triggered CAAs were equired. th the administrator and (DON) on 3/26/18, at 10:38 tor stated it would be expected ompleted when triggered. DS dated 1/26/18, indicated cognitive impairment, suffered lt of a fall prior to admission, havior symptoms, required of one person when , required extensive person for transfers, and assistance of one person for use. The MDS indicated wspapers to read, being bet visits, and participating in vere somewhat important to dated CAA for activities ad not been completed. There t of current activity interests,		 based on their assessments potentially affected by the ci on 4/23/2018, the MDS nurse accuracy of CAA a s and MD surveyors noted to be inaccorresident CAA s will be revisit timeliness and accuracy. Fu CAA being created as of be double checked by regio reimbursement coordinator submission to ensure comp on MDS/CAA was reviewed residents were affected. 3. To enhance currently co operations and under the di DON, on 5/1/2018 all nursin receive in-service training receive in-service training reand federal requirements for documentation, assessment follow up on all missing info ensure clear and correct ca training also emphasized th of the MDS nurse to follow that are not being addresse assessment period and ensure areas are complete. 4. Effective 4/18/2018, a quality-assurance program implemented under the sup MDS nurse to that all reside reviewed at time of admissi ensure CAA s are being co thoroughly and completely. 	ted deficiency, se reviewed DS that urate. All other ewed for urthermore, all 4/23/2018 will nal prior to liance. Policy . No other ompliant rection of the g staff will egarding state r ts and proper rmation to re plans. The e importance up on items d during uring care was ervision of the ents will be on or annual to ompleted		
	issues that result in Review of R14's un the CAA had not be CAA assessment o	reduced activity participation. dated CAA for falls revealed een completed. There was no f physical limitations, oses, history of falls,		be care planned and comm staff via care sheets and co book if new interventions in of CAA□s will be completed and timeliness; they will be MDS nurse 2 audits per we	unicated to mmunication place. Audits I for accuracy completed by		

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	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G	· · ·	PLETED
		245323	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 636	Continued From pa	age 28	F 636	6		
	laboratory findings, or environmental factors.then 1 audit weekly x 2 monthsAdditionally, there was no analysis of the findingscompliance in this area. Any dof the CAA.will be corrected on the spot, aThe regional director of clinical services waswill be documented and submiinterviewed on 3/22/18, at 8:29 a.m. during whichmonthly quality-assurance con		ciencies the checks d at the			
	she confirmed R14 had not been fully o	's CAA's for activities and falls completed.		meeting for further review or corraction.5. MDS nurse will be responsib	ective	
	Region MDS/CAA I indicated would con and stated requirer of the MDS and CA member to comple assessments and N CAAs and care pla	Superior Healthcare Management Minnesota ion MDS/CAA Policy effective 3/22/18, cated would comply with all applicable federal stated requirements related to the completion ne MDS and CAAs and directed each team nber to complete their designated essments and MDS sections along with the As and care plan for the items that are pered on their section of the MDS for whichPOC.	FUC.			
	Assessment Instru indicated: The RAI consisted Minimum Data Set Assessment (CAA) Guidelines. The Ca residents who had	of three basic components: (MDS) Version 3.0, Care Area process and RAI Utilization are Areas triggered identified been or were at risk for				
	required further ass CAA was the further areas in order to de required intervention manual further indi- completed in conju	functional problems and sessment. The completion of a er investigation of the triggered etermine if the care area ons and care planning. The RAI cated that CAAs must be nction with the completion of ssion, annual, and significant				

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 660 SS=D	CFR(s): 483.21(c)(§483.21(c)(1) Disch The facility must de effective discharge on the resident's dis of residents to be a transition them to p	1)(i)-(ix) harge Planning Process evelop and implement an planning process that focuses scharge goals, the preparation active partners and effectively ost-discharge care, and the	F	660			
	readmissions. The process must be co- rights set forth at 48 (i) Ensure that the co- resident are identified development of a do- resident. (ii) Include regular re- identify changes that discharge plan. The updated, as needed (iii) Involve the inter-	ischarge plan for each re-evaluation of residents to at require modification of the e discharge plan must be d, to reflect these changes. rdisciplinary team, as defined , in the ongoing process of					
	 (iv) Consider careginant and the resident's of person(s) capacity arequired care, as particular discharge needs. (v) Involve the resident representative in the discharge plan and resident representative in the discharge plan and resident representative the resident representative in the discharge plan and resident representati	iver/support person availability or caregiver's/support and capability to perform art of the identification of dent and resident e development of the inform the resident and ative of the final plan. sident's goals of care and ces. a resident has been asked in receiving information					

Facility ID: 00995

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU		LE CONSTRUCTION		0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIOI DATE
F 660	Continued From pa	-	F 6	60			
	referrals to local co appropriate entities (B) Facilities must comprehensive car appropriate, in resp from referrals to loc appropriate entities (C) If discharge to to not be feasible, t made the determin (viii) For residents SNF or who are dis LTCH, assist reside representatives in s provider by using d limited to SNF, HH, patient assessmen measures, and dat the data is available the post-acute care assessment data, o data on resource u the resident's goals preferences. (ix) Document, con on the resident's ne record, the evaluat needs and discharge evaluation must be discharge plan to fa to avoid unnecessa discharge or transf This REQUIREME	the community is determined the facility must document who ation and why. who are transferred to another scharged to a HHA, IRF, or ents and their resident selecting a post-acute care ata that includes, but is not A, IRF, or LTCH standardized t data, data on quality a on resource use to the extent e. The facility must ensure that e standardized patient data on quality measures, and se is relevant and applicable to s of care and treatment hplete on a timely basis based eeds, and include in the clinical ion of the resident's discharge ge plan. The results of the discussed with the resident or tative. All relevant resident e incorporated into the acilitate its implementation and ary delays in the resident's					
		v, and document review, the ure an appropriate discharge			This Plan of Correction constitutes written allegation of compliance for		

If continuation sheet Page 31 of 250

			()(0) 1		OMB NO.		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED	
		245323	B. WING _		03/2	03/27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	D BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 660	Continued From pa	age 31	F 66	50			
	plan was developed resident (R24) who Findings include: R24 was admitted diagnoses that incl infection following a fluid (CSF) leak, ge and headache. Review of the hosp 12/14/17, indicated for a CSF leak follo resulting infection. and sent to the nur antibiotics until 12/2 a PICC (peripheral line. Review of R24's dis progress note date going to discharge driving herself in he indicated R24 want to a Walgreens clo note also identified	d and implemented for 1 of 1 was discharged to home. to the facility on 12/15/17, with uded but were not limited to: a procedure, cerebrospinal eneralized muscle weakness, tital dismissal summary dated R24 underwent a dural repair owing a lumbar fusion with a R24 was given IV antibiotics sing home to receive IV 21/17. R24 was admitted with ly inserted central catheter) scharge planning revealed a d 12/20/17, indicating R24 was on 12/21/17, or 12/22/17, via er personal car. The note ted her medications to be sent se to where she lived. The R24 would would be working re physician to set up home		 deficiencies cited. However, of this Plan of Correction is r admission that a deficiency e one was cited correctly. This Correction is submitted to marequirements established by federal law. 1. It is the policy of this faciall residents who discharge f have all the information and need to discharge successful would include but not limited medication list, medical and appointments and treatments recapitulation of resident stat discharge plan. When the sureported lack of documentation noted that the practice of dis planning needed to start soo complete for all residents up discharge planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies social services would initiate planning prior to resident discanse planning was revies would initiate planning was revies would was revied would was revied was revied would was revied wa	tot an exists or that s Plan of eet state and lity to ensure rom facility tools they illy. This to: nonmedical s and y. R24 was propriate inveyor on, it was charge ner and be on d not been practice. edure on ewed and discharge charge. that come to		
	discharge planning which indicated R2 personal car at 10: brace and was able living (ADL's) indep indication if R24 wa and doff the back b PICC, if R24 could	ow-up appointments. The next note was dated 12/22/17, 4 discharged home via 00 a.m. R24 wore a back to perform activities of daily bendently. There was no as able to independently don orace, who would care for the independently change the ver spine or if R24 had		facility do so for short stays r potentially affected by the cit Immediately all residents bei discharged were reviewed at plan in place and sent with re ensure successful discharge are alerted a resident is disc planning should start immed therapy and then nursing to g treatments, medications, ada	ed deficiency. ng nd discharge esident to . When staff harging the jately with get current		

Facility ID: 00995

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI				0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
NALKER	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 /ALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 660	Continued From pa	ige 32	F 6	60			
	Additionally, there wisigns and symptom the primary care pri- indication R24 rece medications were, a on those medication need for home care referral to a home h completed and if R2 admission. The document Disc Post-Discharge Pla found in R24's closs incomplete. The su- home health agence names of two agen numbers were liste indication if the age On 3/23/18, at 11:0 (DON) stated the fa- discharging resider teaching should hai indicated if R24 wa back brace, if R24 wa back brace, if R24 wa change the dressin had discharge med the PICC line should	 was no evidence of teaching of ins of infection or when to call ovider. There was no eived medications, what those and if R24 had been educated ns. Although R24 indicated a e, there was no indication a nealth agency had been 24 was accepted for charge Summary and en of Care dated 12/22/17, was ed record. The summary was mmary indicated R24 wanted ey recommendations and the cies and their telephone d. However, there was no encies were contacted. 4 a.m. the director of nursing acility did not have a system for nts. The DON stated patient ve been documented and s able to independently g on the lower spine, if she lications and what they were, ld have been pulled or home een set-up to ensure it's care, 			level of ADL functioning. Discharging residents were audited by SSC to ens all had appropriate discharge plan in place. No other residents were affect The policy and procedure for discharge planning was reviewed on 4/18/2018. 3. To enhance currently compliant operations and under the direction of DON, on 5/1/2018 all staff will attend in-service training regarding this police and the importance of residents discharging with appropriate informate regarding their care to have continuat of their care. The discharge summar and Post-Discharge Plan of Care forr reviewed to assure interdisciplinary approach from each department documenting resident status in eace discipline pre=discharge, education provided, follow up appointments that have been scheduled, and reviewed or resident and/or representative prior to discharge documented in PCC and co filed in resident schart. 4. Effective 4/18/2018, a quality-assurance program was implemented under the supervision of SSC in conjunction with DON to mon any discharges to ensure appropriate planning was completed. The SSC of	sure ted. ge f the cy tion tion ry m ch tt with o copy	
	have been initiated signs and symptom been reviewed, and physician phone nu provided. The DON	nome health agency should and set-up. Additionally, the is of infection should have d the surgeon and primary care imbers should have been I stated the facility did not have and procedure at the time of			designee will complete audits on all residents who have transferred or discharged for next 8 weeks then 50% residents for 4 weeks to ensure staff comply with current policy. Any deficiencies will be corrected on the s and the findings of the quality-assura	spot,	

Facility ID: 00995

TATEMENIT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT	PLE CONSTRUCTION		E SURVEY	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		LDING		COMPLETED	
		245323	B. WING _		03/27/20		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484	3OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 660	Continued From pa	ge 33	F 66	0 quality-assurance committee n further review or corrective act			
F 661 SS=D	Discharge Summar CFR(s): 483.21(c)(/		F 66	5. SSC will be responsible for		5/6/18	
	must have a discha but is not limited to, (i) A recapitulation of includes, but is not of illness/treatment radiology, and cons (ii) A final summary include items in par the time of the discl release to authorize the consent of the r representative. (iii) Reconciliation of medications with th medications (both p over-the-counter). (iv) A post-discharg developed with the and, with the reside representative(s), w adjust to his or her post-discharge plar the individual plans that have been mad care and any post-on- medical service	of the resident's stay that limited to, diagnoses, course or therapy, and pertinent lab, sultation results. of the resident's status to ragraph (b)(1) of §483.20, at harge that is available for ed persons and agencies, with esident or resident's of all pre-discharge e resident's post-discharge prescribed and e plan of care that is participation of the resident which will assist the resident to new living environment. The of care must indicate where to reside, any arrangements de for the resident's follow up discharge medical and					

		(V2) MILLI TI		
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	245323	B. WING _		03/27/2018
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
R REHABILITATION &	HEALTHCARE CENTER		700	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIC
Continued From pa	nge 34	F 66	1	
			deficiencies cited. However, submi of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan	or that
diagnoses that incluing a diagnoses that incluing a diagnose of the second seco	uded but were not limited to: a procedure, cerebrospinal		requirements established by state and federal law.1. It is the policy of this facility to ensure all residents who discharge from facility have all the information and tools they	
12/14/17, indicated for a CSF leak follo spinal incision was staphylococcus epi R24 was given IV a	R24 underwent a dural repair wing a lumbar fusion. The cultured and was infected with dermis and candida albicans. antibiotics and sent to the		would include but not limited to: medication list, medical and nonme appointments and treatments and recapitulation of resident stay. R24 discharged home without compreh discharge summary to ensure resid received continuous and coordinat person-center care. When the surv	edical was iensive dent ed veyor
ANTIBIOTIC report PICC (peripherally placed 12/13/17, and maintenance and c	t dated 12/4/17, indicated a inserted central catheter) was nd provided instructions for are of the line.		noted that the practice of discharge planning needed to start sooner an complete for all residents upon discharging, this practice had not b followed per policy and best practic Immediately RDCS reviewed policy	e nd be peen ce. y and
progress note date going to discharge driving herself in he indicated R24 want	d 12/20/17, indicating R24 was on 12/21/17, or 12/22/17, via er personal car. The note red her medications to be sent		 procedure on discharge planning a social service coordinator would in discharge planning prior to residen discharge. 2. Because many residents that of facility do so for short stays many a social service of servic	itiate t come to
note indicated R24 primary care physic care and follow-up discharge planning which indicated R2	would be working with her cian to set up home health appointments. The next note was dated 12/22/17, 4 discharged home via		potentially affected by the cited def Immediately all residents being discharged were reviewed and disc plan in place and sent with residen ensure successful discharge. Whe	ficiency. charge t to en staff
	PROVIDER OR SUPPLIER REHABILITATION & SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa summary had beer (R24) reviewed why Findings include: R24 was admitted f diagnoses that incluinfection following a fluid (CSF) leak, ge and headache. Review of the hosp 12/14/17, indicated for a CSF leak follor spinal incision was staphylococcus epi R24 was given IV a nursing home to re 12/21/17. Review of the HOM ANTIBIOTIC report PICC (peripherally placed 12/13/17, at maintenance and o Review of R24's dia progress note date going to discharge driving herself in he indicated R24 want to a Walgreens close note indicated R24 primary care physic care and follow-up discharge planning which indicated R24	245323 PROVIDER OR SUPPLIER REHABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 summary had been completed for 1 of 1 resident (R24) reviewed who was discharged to home. Findings include: R24 was admitted to the facility on 12/15/17, with diagnoses that included but were not limited to: infection following a procedure, cerebrospinal fluid (CSF) leak, generalized muscle weakness, and headache. Review of the hospital dismissal summary dated 12/14/17, indicated R24 underwent a dural repair for a CSF leak following a lumbar fusion. The spinal incision was cultured and was infected with staphylococcus epidermis and candida albicans. R24 was given IV antibiotics and sent to the nursing home to receive IV antibiotics until	245323 B. WING	245323 B. WING SREHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE (EACH OEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 34 ID PREFIX summary had been completed for 1 of 1 resident (R24) reviewed who was discharged to home. F 661 Findings include: F 661 R24 was admitted to the facility on 12/15/17, with diagnoses that included but were not limited to: infection following a procedure, cerebrospinal fluid (CSF) leak, generalized muscle weakness, and headache. F 661 Review of the hospital dismissal summary dated 12/14/17, indicated R24 underwent a dural repair for a CSF leak following a lumbar fusion. The spinal incision was cultured and was infected with staphylococcus epidermis and candida albicans. 1. It is the policy of this facility to all residents who discharge from fa have all the information and coordinat and coordinates and coordinates and coordinates and coordinates and coordinates and coordinates neeroived continuous and coordinates and coordinates neeroived continuous and coordinates neeroived continuous and coordinates neeroived the HOME INFUSION ADULT ANTIBIOTIC report dated 12/20/17, indicating R24 wasgioen to ket home health care and follow-up appointments. The ne

Facility ID: 00995

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	. 0938-039 E SURVEY IPLETED
			A. BUILDIN	G		
		245323	B. WING			27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST F WALKER, MN 56484	PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIOI DATE
F 661	Continued From pa	ae 35	F 66	1		
	living (ADL's) indep indication if R24 wa and doff the back b PICC, if R24 could dressing on the low dressing supplies to Additionally, there w symptoms of infecti care provider. Then received medication were, or if R24 knew supposed to be tak the need for home referral to a home h completed. Further record revise discharge summary ensure R24 receives person-centered ca document Discharge Post-Discharge Pla found in R24's closs R24's functional lew minimal and non-in minimal nursing sur was admitted for IV strengthening. The wanted home healt The names of two a numbers were lister if the agencies were one would be able to needs. The summa information from ph therapy, information who would care for surgical wound and	endently. There was no as able to independently don race, who would care for the independently change the ver spine or if R24 had o change the dressing. was no teaching of signs and ion or when to call the primary e was no indication R24 ns, what those medications w what medications she was ing. Although R24 identified care, there was no indication a nealth agency had been	F 00	 therapy and then nursing to treatments, medications, are equipment in check, along level of ADL functioning so get summary with them to be continuation of care. All rest discharging is now given fur summary at time of dischar residents were affected. The procedure for discharge platerviewed on 4/18/2018. To enhance currently cooperations and under the d DON, on 5/1/2018 all staff vin-service training regarding and the importance of resided ischarging with appropriat regarding their care to have of their care. The discharge and Post-Discharge Plan or reviewed to assure interdistapproach from each depart documenting resident s st discipline pre=discharge, exprovided, follow up appoint have been scheduled, and resident and/or representate discharge documented in F filed in resident schart. Effective 4/18/2018, a quality-assurance program implemented under the sup SSC in conjunction with DC any discharges to ensure a planning was completed. T designee will complete aud residents who have transfe discharged for next 8 week residents for 4 weeks to en 	daptive with current resident can ensure sidents Il discharge rge. No other he policy and anning was ompliant irection of the will attend g this policy dents e information e continuation e summary f Care form ciplinary thent atus in each ducation ments that reviewed with tive prior to PCC and copy was pervision of the DN to monitor ppropriate The SSC or its on all rred or s then 50% of	

Facility ID: 00995

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOI	ED: 05/04/2018 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY COMPLETED
		245323	B. WING)3/27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
WALKER	REHABILITATION &	HEALTHCARE CENTER			9 BIRCHWOOD AVENUE WEST PO BOX 700 ALKER, MN 56484	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	(DON) on 3/23/18, discharge summary stay that included d pertinent lab values reports, a final sum and a post discharg completed for R24.	th the director of nursing at 11:04 a.m. she confirmed a with a recapitulation of R24's iagnoses, course of treatment, radiology and consultation mary of the residents status, ge plan had not been	F 6		comply with current policy. Any deficiencies will be corrected on the spo and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting for further review or corrective action. 5. SSC will be responsible for this POO	or C.
SS=D	CFR(s): 483.24(a)(§483.24(a)(2) A resout activities of dail services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility fa assistance with incorresidents (R2, R23) staff for incontinent facility failed to assist with shaving. Findings include: R2's annual Minimu 11/2/17, identified F impairment and diadisease, dementia indicated R2 required all activities of daily	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and	F 6		This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to provid consistent quality care to residents needing assistance with their ADL's. Some of the ways this is done is by gathering data through assessments to ensure all residents needing assistance with ADL's such as ambulating, groomin dressing, and bathing are identified and assisted appropriately. In this case, after the state of the state of the state of the state of the state of the state of t	t de ig,

Facility ID: 00995

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			ОМ	FORM / IB NO.	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (.		E SURVEY PLETED
		245323	B. WING	i		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 70 VALKER, MN 56484	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From pa	ge 37 nence Care Area Assessment	Fθ	677	the assistance they needed a review	/ of	
	(CAA) dated 11/3/1	7, indicated R2 was ler and had a colostomy.			residents was completed. R23 had fa hair and needed to have removed. H	acial	
	R2's Bladder Asses	sment Form dated 12/31/17,			care plan states to shave daily. R2 a R23 needs assistance with incontine	ind ent	
	physical impairmen	inctional incontinence. Due to ts and cognitive deficits, R2			care. It is identified both are complet dependent on staff for incontinent ca	are.	
		oropriate for bladder retraining. d 12/28/17, directed the staff			Since survey, staff have been educa on importance of providing cares to residents based on their care plan a		
		check and change schedule of			following their care sheets. 2. Because all residents have cons changing needs all are potentially aff	stantly	
		continuous observations from a.m. R2 was not observed to			by the cited deficiency, on 4/23/2018 MDS nurse reviewed residents need	8, the ling	
	- At 7:05 a.m. R2 w wheelchair in her ro	as observed seated in a oom.			assistance with incontinence care ar shaving and ensure plan of care is c based on needs. MDS nurse will rev	orrect iew	
	wheeled R2 from h	ealth unit coordinator (HUC) er room to the dining room. IUC served R2 breakfast and			each quarter if resident goals being i and ensure staff follow through with A current review was completed of a	cares.	
	was observed to as - At 8:07 a.m. the H	sist R2 with the meal. IUC wheeled R2 out of the			residents with similar ADL needs. Po and procedure on ADL's has been		
	- At 8:12 a.m. R2 w	had finished her meal. as wheeled back to the room. as wheeled into the activity			reviewed. No other residents were affected. 3. To enhance currently compliant		
	room by the activity - At 9:53 a.m. nursi	director. ng assistant (NA)-B stated R2			operations and under the direction or director of nurses, on 5/1/2018 all nu		
	she had not had tim	out of bed at 6:30 a.m. and ne to assist her since that time. B wheeled R2 to her room			staff will receive in-service training regarding changes in resident's cond dignity in cares and following care sh		
	and assisted R2 to to the bed via a full	transfer from the wheelchair body mechanical lift. Once in			The training will emphasize the importance of monitoring ADL's and		
	was observed to be	R2's incontinence brief. R2 incontinent of urine.			reviewing that poor incontinent care lead to skin breakdown. Staff were		
	assisted with incont	3 confirmed R2 had last been tinence cares at 6:30 a.m. (a 30 minutes earlier).			evaluated on ADL's and reviewed AL competencies. Reviewed staff expectations regarding following car sheets and performing ADL's accord	е	

Facility ID: 00995

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STATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				3		
		245323	B. WING		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX T WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 677	On 3/22/18, at 2:58 stated R2 was to be cares every two ho plan. R23's quarterly MD with severe cognitivi including dementia (inability to speak). required extensive daily living and indi incontinent of blado R23's annual MDS R23 as being totally bladder. R23's Urinary Incor identified R23 as be bowel and bladder to check and change two hours. R23's care plan dat check and change two hours. During continuous 7:13 a.m. to 10:07 receive assistance - At 7:13 a.m. NA-E transfer R23 from to body mechanical lift - At 8:46 a.m. R23 preakfast meal.	 a p.m. registered nurse (RN)-E a assisted with incontinence urs as directed by the care a directed by the care b dated 3/9/18, identified R23 a impairment and diagnoses a history of stroke and aphasia The MDS indicated R23 a assistance with all activity of cated he was totally der. dated 10/13/17, also identified a incontinent of bowel and a ntinence CAA dated 10/9/17, eing totally incontinent of and directed the staff to assist a R23's incontinence brief a ted 7/19/17, directed staff to R23's incontinence brief every observations on 3/22/18, from p.m. R23 was not observed to with incontinence cares. a and NA-C were observed to bed to a wheelchair via a full 	F 677	 7 resident cares and staff expectation job performance. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision DON and MDS to monitor resident needing assistance with ADL's. The or designee will audit all residents 5 days (days and evenings) to enst aspects of their ADL's are complete After the one week will monitor 5 residents weekly for 4 weeks and the residents weekly for 2 months. All residents will be reviewed at time of quarterly or annual to ensure not a significant change. Any deficiencies be corrected on the spot, and the for the quality-assurance committee meet further review or corrective action. 5. MDS nurse will be responsible POC. 	n of the s ne DON daily for ure all ed. then 3 of s will indings Il be monthly ing for	

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STATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245323	B. WING			8/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		0/2//2010
		HEALTHCARE CENTER		BOX 700	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 677	room to the nurses - At 10:00 a.m. R22 - At 10: 05 a.m. R2 NA-C to bed via a f was observed to be - At 10:10 a.m. NA- had not received as cares since 7:13 a. minutes earlier). On 3/23/18, at 10:3 to receive assistant every two hours as The Toileting policy 12/23/17, directed the toilet in a timely individualized plant that if a resident wa utilization of the toil a check and chang and bladder assess R23's care plan da required extensive activities of daily liv specifically direct s shaving facial hair. On 3/19/18, at 10:4 stated the facility st regular basis. FM-E preference was to she had talked to th R23 continued to b	was wheeled from the activity station. 3 was wheeled to his room. 3 was transferred by NA-B and full body mechanical lift. R23 e incontinent of stool. B and NA-C confirmed R23 ssistance with incontinence m. (a total of 2 hours and 50 35 a.m. RN-B stated R23 was ce with incontinence cares directed by the care plan. 7 and procedure dated the staff to assist residents to 7 manner in accordance to their of care. The policy indicated as unable to physically tolerate let, the staff were to adhere to e program based on a bowel sment. ted 12/22/17, indicated R23 assistance of one staff for all ring. The care plan did not taff regarding the frequency of	F 67	77		

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		וחוד			0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	· ·				
		245323	B. WING			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7	00	
				V	NALKER, MN 56484		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
	1		ı.		DEFICIENCY)		
F 677	Continued From no	an 10	БО				
1 077	Continued From pa	ige 40	F 6	11			
	On 3/19/18. at 11:0	0 a.m. R23 was observed in					
 On 3/19/18, at 11:00 a.m. R23 was observed in the dining room. R23 was observed to have a 2-3 day growth of facial hair stubble. On 3/20/18, at 5:00 p.m. R23 was observed in the dining room. R23 continued to be in need of a shave. On 3/21/18, at 12:44 p.m. R23 was observed in the dining room. R23 continued to be in need of a shave. On 3/21/18, at 1:40 p.m. the director of nursing (DON) stated residents were to be assisted with shaving daily according to their personal 							
	2-3 day growth of fa	acial hair stubble.					
	On 2/20/18 at 5.00	n m P23 was absorved in the					
	•						
	J. J						
	On 3/21/18, at 12:44 p.m. R23 was observed in the dining room. R23 continued to be in need o a shave. On 3/21/18, at 1:40 p.m. the director of nursing						
	. ,						
		ding to their personal					
	protoronool						
						TION (X5) JLD BE COMPLETION	
	 dining room. R23 continued to be in need of a shave. On 3/21/18, at 12:44 p.m. R23 was observed in the dining room. R23 continued to be in need of a shave. On 3/21/18, at 1:40 p.m. the director of nursing (DON) stated residents were to be assisted with shaving daily according to their personal 						
		-					
		-					
	with shaving.	nad not received assistance					
	mar onaving.						
		C stated male residents were					
		ce with shaving in accordance					
	to their previous pre	erences.					
	On 3/24/18, at 9:20	a.m. R23 was observed					
		Ichair in his room. R23's					

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PRINTED: 05/04/2018

FATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION (X3) [DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			OMPLETED
		245323	B. WING		3/27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 677	Continued From pa	ge 41	F 67	7	
	cheeks had been s and chin had not be	haved, however, R23's neck een shaved.			
	chance to assist R2 when she did shave neck or under his c	stated she had not had a with shaving all week and him, he would not allow his hin to be shaved. NA-B stated assistance with shaving daily.			
F 679 SS=D	directed staff to pro care. The policy did frequently a resider with shaving. Activities Meet Inter	3/17, Shaving the Resident, vide cleanliness and skin d not direct the staff on how nt was to receive assistance rest/Needs Each Resident	F 67	9	5/6/18
	§483.24(c) Activitie §483.24(c)(1) The f the comprehensive and the preference program to support activities, both facili individual activities designed to meet th physical, mental, ar each resident, enco and interaction in th	s. facility must provide, based on assessment and care plan s of each resident, an ongoing residents in their choice of ity-sponsored group and and independent activities, he interests of and support the nd psychosocial well-being of buraging both independence			
	Based on observat review, the facility facentered activities	tion, interview and document ailed to assess resident preferences and develop ventions for 1 of 2 residents activities.		F679 SS=D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	

Event ID: RI9311

Facility ID: 00995

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G		PLETED
		245323	B. WING		03/27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		Г РО ВОХ 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 679	Continued From pa	ge 42	F 679	9		
	R14's physician nursing home admission assessment dated 1/23/18, indicated R14 had been admitted to the facility on 1/19/18, and had diagnoses that included, but were not limited to: closed nondisplaced fracture of the seventh cervical vertebra with routine healing, high blood pressure, type II diabetes, late onset moderately advanced Alzheimer's disease with behavioral disturbance. The admission Minimum Data Set (MDS) dated 1/26/18, indicated R14 had moderate cognitive impairment, suffered a fracture as a result of a fall prior to admission, had not displayed any inappropriate behavior symptoms, required limited assistance of one person when ambulating in room, required extensive assistance of one person for transfers, and required extensive assistance of one person for			requirements established federal law. 1. It is the policy of this to activities meet interest/ner residents. Some of the w is by gathering data throut to ensure all residents an members can meet with a determine types of activiti may like and or participate after the survey determine for R14.No interview com resident or family and res offered any participation. identified resident interest completed. Assessments completed, and care plan 2. Because all residents participate in some activiti	facility to provide eds of all rays this is done gh assessments d family activities to es each resident e in. In this case, ed lack of activity pleted with ident was not No care plan ts nor were CAA were updated. should	
	dressing and toilet having books or ne around animals or p	use. The MDS indicated wspapers to read, being pet visits, and participating in vere somewhat important to		potentially affected by the MDS nurse and activities care plans to update accorreview each quarter if res met and ensure staff follo meeting activity interests.	cited deficiency. reviewed all ordingly. Will ident goals being w through with	
	7:18 p.m., 3/21/18, and 3/22/18, from 8	on 3/20/18, from 12:48 p.m. to from 9:00 a.m. to 1:00 p.m., 3:02 a.m. to 2:30 p.m R14 ctivities and did not attend any se times.		review was completed of activities to ensure all res opportunity to be involved that interests them. Policy on activities has been rev residents were affected.	idents have I in something / and procedure	
	was no assessmen activities of interest Care Area Assessn revealed it had not	rd was reviewed and there t of leisure pursuits or completed. R14's undated nent (CAA) for activities been completed. There was current activity interests, or to admission,		 To enhance currently operations and under the director of nurses, on 5/1/ receive in-service training importance of activities an residents to reduce isolati 4. Effective 4/17/2018, a 	direction of the /2018 all staff will regarding nd engaging all ion.	

Facility ID: 00995

		AND HUMAN SERVICES				05/04/201 APPROVE 0938-039	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		245323	B. WING _		03/	27/2018	
NAME OF F	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 679 F 684 SS=D	resident had that co issues that result in Review of R14's ac 1/29/18, indicated t resident to activity p physical activity, ph exercise group, wa mobility." A copy of was requested but On 3/22/18, at 8:29 clinical services (RI confirmed R14 had assessed for activit comprehensive car interventions includ not been developed The Superior Healt Region policy for Ac indicated that withir admission to the fa would be assessed on the residents ch be developed. Quality of Care CFR(s): 483.25 § 483.25 Quality of	e skills or knowledge the build be passed onto others, or a reduced activity participation. tivities care plan dated he following: "Invite the brograms that encourage hysical mobility, such as lking activities to promote R14's activity participation log not provided. a.m. the regional director of DCS) was interviewed and not been comprehensively ties of interest and a e plan with individualized ling activities of interest had d. hcare Management Minnesota ctivities dated 12/23/17, n 14 day of a residents cility a residents activities for and an activity plan based oices and preferences would	F 67	implemented under the superactivities department to more engagement. The activities will perform evaluation of all review their activities of choir residents 5/2/2018 and cale activities will be created bas needs. Week 2 all residents audited to ensure activities of the according to their interests them are available or that reparticipated in activities of the according to their interests there week x 4 weeks then 2 at x 2 months to ensure compliarea. All residents will be revof quarterly or annual to ensist significant change. Any defies be corrected on the spot, and of the quality-assurance committed quality-assurance committed further review or corrective at 5. Activity coordinator will be for this POC.	hitor resident's coordinator residents to ice on ndar for ed on resident will be hat interest esidents heir choice hen 4 audits audits weekly iance in this viewed at time cure not a ciencies will d the findings ecks will be at the monthly e meeting for action.	5/6/18	
	applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pr	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered					

Facility ID: 00995

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	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MI II TI	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245323	B. WING _		03/	27/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 684	Continued From pa	ige 44	F 68	4		
	care plan, and the	-				
	Based on observa review, the facility f pacemaker function performed for 1 of utilized a cardiac pa Findings include: R6's quarterly Minin 1/17/18, identified F impairment and dia disorder, chronic at disease. The MDS limited assistance of daily living. R6's Hospital Disch indicated R6 was to over the telephone on 7/18/17.	tion, interview, and record ailed to ensure routine hality checks had been 1 resident (R6) reviewed who acemaker. mum Data Set (MDS) dated R6 with moderate cognitive gnoses including: depressive rial fibrillation and mitral valve also indicated R6 required of one staff for all activities of harge Summary dated 6/19/17, o complete a pacemaker check using a remote home monitor		 This Plan of Correction constitutivity written allegation of compliance of deficiencies cited. However, subsof this Plan of Correction is not a admission that a deficiency exist one was cited correctly. This Place Correction is submitted to meet requirements established by state federal law. 1. It is the policy of this facility twith monitoring residents with chases for appropriate treatments care in accordance of profession standards. Some of the many we this has been accomplished for Plane adequate checks and completed documentation is in place to doc results. Care plan and progress updated. 2. Because many residents has potential for pacemakers many adminimum statements in the statements of the many we can be added to document the statements and progress updated. 	for the mission s or that an of e and o assist ronic ent and aal ays that R6 is by e and ument note	
	pacemaker due to the staff to monitor altered cardiac out such as dizziness, pulse rate lower tha than baseline blood not direct the staff to pacemaker via tele R6's clinical record to the pacemaker r	atrial fibrillation and directed for signs and symptoms of out or pacemaker malfunction syncope, difficult breathing, an programmed rate or lower d pressures. The care plan did to assist to monitor the phonic monitoring.		potential for pacemakers many a potential for pacemakers many a potentially affected by the cited o on 4/17/2018, the DON reviewed appropriate pacemaker checks. educated on consistent impleme MD orders on any resident need comprehensive monitoring and importance of documenting resu other residents were affected. 3. To enhance currently compli operations and under the direction DON, on 5/1/2018 all nursing star receive in-service training regard normal monitoring, reporting data	leficiency, I R6 for Staff ntation of ing Its. No ant on of the iff will ling	

Facility ID: 00995

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED
		245323	B. WING _		03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	O BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	assistance of one	staff member. R6 was not	F 68	checks. All checks should b		
	or fatigue while wa - At 1:05 p.m. licen confirmed R6 had scheduled telephor completed by the r scheduled times w electronic Medicati (EMAR). LPN-B re the EMAR did not i - At 1:17 p.m. LPN room and located a monitoring device. idea the last time F - At 3:00 p.m. regis R6's clinical record lacked documentat checked. RN-E sta into the concern. On 3/23/18, at 11:5	y shortness of breath, dizziness lking. sed practical nurse (LPN)-B a pacemaker and stated the nic monitoring was to be nursing staff. LPN-A stated the ere to be identified on the on Administration Records eviewed R6's EMAR and stated nclude pacemaker monitoring. -B entered the medication a pacemaker telephonic LPN-B confirmed she had no R6 utilized the machine. stered nurse (RN)-E reviewed and stated the clinical record tion as to the last time it was ated she would have to look		in PCC with corresponding All new admissions will be a they have a pacemaker and up initiated at time of admis compliance in system. 4. Effective 4/17/2018, a quality-assurance program implemented under the sup DON to monitor R6. The D designated quality-assurance representative will perform to systematic changes: audits residents and new admission pacemaker for pacemaker of months. Any deficiencies with on the spot, findings of the quality-assurance checks we documented and submitted quality-assurance committed further review or corrective 5. DON will be responsible	assessed if I proper follow sion to assure was ervision of the ON or ce the following done on all ons with checks next 6 ill be corrected will be at the monthly e meeting for action.	
	the pacemaker evaluation of the pacemaker monitor nurse's appointment then identified R6 H 2/13/18. LPN-A state the pacemaker check completion of the provide completion of the provide the calendar, LPN-					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING _		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	the pacemaker che February 2018, how documented the more RN-D stated at the additional appointm RN-D stated the face of documentation fr which would indicat pacemaker. RN-D clinic to contact the - At 9:50 a.m. the S was interviewed via stated R6's pacema 2/13/18, and R6 wat evaluation. R6 would appointment in the review. - At 10:51 a.m. RN- to R6's family mem be seen in the clinic RN-D confirmed the upcoming appointm Treatment/Devices CFR(s): 483.25(a)(1) §483.25(a) Vision a To ensure that reside and assistive device hearing abilities, the assist the resident-	 D stated she had completed ck via the telephone in wever, she had not onitoring in the medical record. time of the monitoring, an eent had not been made. cility had not received any type om the pacemaker clinic e any concerns with the stated she would expect the facility if there was a problem. anford Pacemaker Clinic staff telephone. The clinic staff aker check was completed on is due for a cardiologist Id be scheduled an next two months for further D stated he/she had spoken ber who was aware R6 was to c for a cardiac evaluations. e facility was not aware of the nent. to Maintain Hearing/Vision 1)(2) 	F 68	4		5/6/18

Facility ID: 00995

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PRINTED: 05/04/2018

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION	MB NO. 093 (X3) DATE SUF	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G	COMPLET	
		245323	B. WING		03/27/2	018
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		700	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CON	(X5) IPLETIC DATE
F 685	Continued From pa	ge 47	F 68	5		
		rranging for transportation to of a practitioner specializing in				
t <u> </u> 	the treatment of vis	ion or hearing impairment or ssional specializing in the				
	provision of vision of	or hearing assistive devices. NT is not met as evidenced				
	Based on observation review, the facility f	tion, interview and document ailed to provide assistance to		This Plan of Correction constitute written allegation of compliance fo	r the	
		s were available to maintain ation needs for 1 of 1 resident hearing.		deficiencies cited. However, subm of this Plan of Correction is not an admission that a deficiency exists	or that	
	Findings include:			one was cited correctly. This Plan Correction is submitted to meet requirements established by state		
	according to the ad	cognitive impairment, mission Minimum Data Set I8. Additionally, the MDS		federal law. 1. It is the policy of this facility to residents have treatments/devices	ensure	
	indicated had not d behavior symptoms	and used a hearing aid or ance with no difficulty hearing		maintain hearing and vision. Som many ways that this has been accomplished for R14 is to have re	e of the	
		id/appliance was used.		hearing aids kept on resident in m and remove and place in med cart	orning	
	addressed the use care plan was revis	ted 1/24/18, had not of hearing aids for R14. The ed on 3/22/18, and directed I hearing aides and if they		evening. Spoke with friend about s keep in position but stated residen likely still remove has never liked w them. Staff were educated if reside	t would vearing	
		k in R14's shirt pocket.		them out look in shirt pocket as it i he likes to put them. Plenty of batt		
		8 p.m. it was noted that R14 earing aids, rather they were de stand.		 were placed in med cart so replace are always available. Care plan an progress note updated. 2. Because many residents have 	d	
		on 3/21/18, at 9:00 a.m. and I did not have hearing aids in vation.		hearing or visual deficits many are potentially affected by the cited de on 4/17/2018, the DON reviewed a residents with hearing aids. Staff	ficiency,	
		a.m. R14 was observed after 14 was assisted with dressing		educated on consistent use of hea aids and glasses. Ensure follow up		

Facility ID: 00995

							0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (2		E SURVEY PLETED	
		245323	B. WING			03/2	27/2018	
AME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
VALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484			OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE	
F 685	Continued From pa	qe 48	F 6	85				
	R14's hearing aids hearing aids did nor asked where R14's stated she did not k where R14's batteri did not know. On 3/23/18, at 8:32 reading an article a director stated R14 in. R14 was asked and stated they wer hearing. He stated did not want to wea On 3/23/18, at 10:3 hearing aide in and director was intervie wore hearing aids and aids and identified of some missing parts left hearing aid and activity director stat aid in his ear and se On 3/22/18, at 8:29 clinical services wa R14 should have be aids if that was his current care plan ha hearing aids to wea The Superior Healt Region policy for he indicated to assist t	3 a.m. R14 was seen with one was leaving it in. The activity ewed and explained that she and looked at R14's hearing one of the hearing aids had s, then put the batteries in the put it in R14's ear. The ted that R14 left the hearing eemed to hear better. a.m. the regional director of s interviewed and confirmed een assisted to wear hearing choice, and confirmed R14's ad not identified R14 had ar. hcare Management Minnesota earing aid use dated 12/23/17, he resident with use and care			resident that does not utilize or have available any aids that are listed on or sheets. No other residents were affe 3. To enhance currently compliant operations and under the direction of director of nurses, on 5/1/2018 all sta receive in-service training regarding of hearing or visual aids. It is noted of care sheets and must be updated if to is a change or a problem with the aid supplied. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of DON to monitor residents with hearin aids. The DON or designated quality-assurance representative will perform the following systematic cha audits done on all residents to ensur- hearing aids and glasses on daily for week then 3 residents for 2 weeks the 1 resident weekly for 4 weeks to ensur- compliance. Any deficiencies will be corrected on the spot, and the finding the quality-assurance committee meeting further review or corrective action. 5. DON will be responsible for this	care ccted. f the aff will use on there ds of the ng anges: re r one nen on sure gs of onthly g for		
F 686	of hearing aides for Treatment/Svcs to	maximum effectiveness.	F 6					

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			()(0)			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X3)) DATE SURVEY COMPLETED	
		245323	B. WING		03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	DX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIO DATE	
F 686	Continued From pa	ge 49	F 686			
SS=G		-				
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility fa assessment, monitor	sure ulcers. rehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition hey were unavoidable; and pressure ulcers receives and ards of practice, to event infection and prevent veloping. NT is not met as evidenced tion, interview and document ailed to provide appropriate pring and interventions to		This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission		
	promote healing of of 6 residents (R5, who had current pre failure to adequatel implement intervent for R5 who develop	oment of pressure ulcers and current pressure ulcers for 4 R18, R2, R23) in the sample essure ulcers. The facility's y assess, monitor and/or tions resulted in actual harm ed pressure ulcers while at R18 who had recurrent		 of this Plan of Correction is not an admission that a deficiency exists or th one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to prov treatment and services to prevent pressure ulcers. One of the many ways that this has been achieved for R5, R2 	ide s	
	pressure ulcers and	t risk for the development of d did not receive timely ositioning and developed two		R2, and R18 was to have pressure relieving cushions however nothing specific applied, documentation of wounds were not consistent, treatment not clear and resident can refuse to offload at times, but nothing was care		

Facility ID: 00995

TATEMENT	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLF C	ONSTRUCTION	MB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245323	B. WING			03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER			BIRCHWOOD AVENUE WEST PO BOX .KER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 686	Continued From pa	ge 50	F 68	6			
	impairment and dia disease, quadripleg indicated R5 require members for bed m activities of daily liv R5 at risk for the de R5's admission MD as dependent upon living and at risk for ulcers. R5's Pressure Ulce (CAA) dated 9/6/17 development of pre dependence upon s bowel incontinence staff to complete we monitor R5's skin w cares. The Braden Scale (R5 had moderate cognitive gnoses included Parkinson's jia and depression. The MDS ed total assistance of two staff nobility, transfers and all ing. The MDS also identified evelopment of pressure ulcers. IS dated 9/1/17, identified R5 staff for all activities of daily the development of pressure r Care Area Assessment , identified R5 at risk for the ssure ulcers due to staff for repositioning and . The assessment directed eekly skin assessments and to while assisting with personal		futed h C w pd ir o ir d printed h C w pd ir o ir d printed h d printed h h	ntervention on her care plan to pro- urther breakdown. R18 was deter to be turned and repositioned q2h luring survey noted this was not appening as directed by care plan Consistently no documentation of vorsening/improvement of wounds roper interventions not in place, a locumentation as well as rounds a noonsistent. After survey noted th f the entire wound care system mediately a new structure was leveloped to have weekly rounds roper follow up on all residents w mpaired skin integrity. R 23 was eevaluated for pressure risk, tissu- plerance test completed and skin eviewed. Plan in place, skin intace are plan and care sheets updated as had OT evaluate for assistive levices, air mattress has been put lace, reassessed skin and on turn epo q2h, boots while in bed, treat ave been updated, and wounds a lealing. R18 has been assessed t litered skin integrity. Skin check	mined but n. s, and are he lack e lack and ith ie t, and d. R 5 t in n and ments are	
	11/22/17, indicated blanchable" area ov form did not identify had skin change/su skin care directives R5's care plan date assist R5 with repo hours.	ace Observation form dated R5 displayed a "pink, ver boney prominences. The v which boney prominences isceptibility to pressure nor any for the staff to implement. d 8/28/17, directed the staff to sitioning at least every two der dated 11/29/17, directed		n u s re p 2 p d b t t	ompleted, boots on while in bed, nattress added, wound care been pdated and turn and repo q2h. Ca heets and care plans updated. Th eceived further training on wound rogram requirements. Because all residents are at ris otential to alteration in skin integr lue to illness or have potential for rreakdown all are potentially affec ne cited deficiency, wound locumentation has been reviewed interventions for prevention are in	are ne DON sk for ity or skin ted by	

Facility ID: 00995

TATEMEN	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CO	ISTRUCTION		0938-039 SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			СОМ	PLETED
		245323	B. WING			03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER		·	STREE	TADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			RCHWOOD AVENUE WEST PO BO ER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 686	Continued From pa	ae 51	F 68	6			
F 080	staff to apply a Derrito the coccyx every addition, R5's Orde order for the same directed the staff to (foam dressing) to change every three Review of R5's Pro- revealed the followi - 2/2/18, R5's upper area was red, barrier - 2/3/18, redness to sacral area, barrier - 2/4/18, redness to sacral area, barrier - 2/6/18, small super upper buttocks and applied and reposit provided. - 2/12/18, scabbed scabbed area to sa -2/16/18, scabbed scabbed area to sa -2/16/18, scabbed a sacrum, barrier cre -2/20/18, two super buttocks measures cm. The left buttoc cm covered with hy stretchy dressing w	 Film Thick Sacral Dressing three days, and as needed. In r Summary also included an wound dated 10/3/17, which apply an Allevyn Dressing the left buttock wound and to days until healed. gress Notes (nurses notes) ing information: r buttocks, coccyx and sacral er cream applied. upper buttocks, coccyx, and cream applied. upper buttocks, coccyx, and cream applied. apply an applied. apply an applied. apply an applied. apper buttocks, coccyx, and cream applied. apper buttocks, coccyx, and cream applied. apper buttocks, coccyx, and cream applied. apply an applied. area to left buttocks and small area to left buttocks and am applied. area to left buttocks and an applied. area to left buttocks and 	F 68	and We statim bru ras ulc as: inte inte we ref im cal No po 3. op dir RN cla he co an: for on fro on trate as: inte inte inte inte inte inte inte inte	d documented clearly on care eekly skin audits are complete ff update DON on any new a mediately including reporting lises, skin tears, skin breakde shes. All current resident with ers were assessed for comple- sessment along with appropri- erventions. Implementation of erventions is reviewed on rou- ekly. Staff to alert DON is res- uses otherwise. Staff educate portance of offloading, reposi- re plan updated, care sheets other residents were affecte- icy on wound care has been To enhance currently comple- erations and under the directi- ector of nurses, on 4/25/18 al- ls received an additional 6 ho ssroom training from mentor r wound rounding nurse which sisted of handouts, question swers, actual wound dressing resident, lecture and agenda- items identified needing imple- m POC and observations. In 5/1/2018 all staff received in- ining for monitoring skin and eas, to ensure staff always us erventions in place and under loading to prevent further alter n integrity. The training emph portance of following all interv- effective skin maintenance a porting of changes in skin cor	ed, and reas noted of any own or pressure rehensive ate f those nds ident ed on tioning, updated. d. The updated. d. The updated. iant on of the I facility urs of DON and n and g change focused rovement addition, service pressure e stand rations in pasizes the ventions nd	

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		& MEDICAID SERVICES					0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	,	SURVEY PLETED	
		245323	B. WING	WING			7/2018	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484	'O BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From pa	ge 52	F 6	86				
	 2/26/18, friction shand sacral region, breposition every two 3/3/18, dry areas for region, barrier createring and sacral region, barrier createring and the skin) applied. 3/6/18, dry areas for dressing applied. A Weekly Skin Rev R5 had "superficial and "excoriation on excortation excortation on excortation on excortation on excortation excortatio	hear to bilateral upper buttocks barrier cream applied, b hours. to upper buttocks and sacral m applied. to upper buttocks and sacral ng (a foam pad to cover the esive edge to adhere to the to bilateral buttocks foam iew dated 3/10/18, indicated open area on sacral areas" the buttocks." d areas to bilateral buttocks, loid placed s with dry area to bilateral I region, foam dressing d areas to upper bilateral Tegaderm hydrocolloid ical record lacked a weekly wound which would include he wound, (length, width and wound and surrounding rent interventions. ical record lacked indication cian had been notified of the s.			assessment of skin, pressure ulcers a implementation of appropriate interventions. 4. Effective 4/24/2018, a quality-assurance program was implemented under the supervision of director of nurses to monitor resident with impaired skin integrity and updat MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the follow systematic changes: the DON or des will ensure audits of all residents that dependent on staff for preventing skin breakdown (incontinent, unable to off need pressure relieving devices, exis skin breakdown, etc.) daily for 5 days then 5 residents for 4 weeks to ensur compliance than 2 residents weekly x months. Any deficiencies will be corred on the spot, and the findings of the quality-assurance checks will be documented and submitted at the mod guality-assurance committee meeting further review or corrective action. 5. DON will be responsible for this POC.	of the ts ting , ing signee t are n fload, sting s, re x 2 ected onthly g for		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		245323	B. WING			07/0040		
	PROVIDER OR SUPPLIER	240323		STREET ADDRESS, CITY, STATE, ZIP CODE	03	6/27/2018		
		HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BC WALKER, MN 56484	X 700	700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE		
F 686	wound. The docum had initialed both d which indicated the wound, even thoug actually applied. On 3/20/18, at 5:00 in a wheelchair in th for supper. -At 5:05 p.m. regist evening meal. -At 5:20 p.m. RN-D turned the televisio -At 5:55 p.m. R5 re Nursing assistant (assisted R5 to was change into a hosp repositioned. -At 6:06 p.m. NA-D in the chair and cor -At 7:50 p.m. NA-D room and transferre bed. R5's wheelcha redistribution seat of was covered with a hydrocolloid dressin the wound was dee - At 7:55 p.m. NA-A bed at 4:00 p.m. ar repositioned for 3 h stated with only two doing the best they unable to provide a repositioning for all On 3/21/19, at 1:10 (DON) and the registion	nentation revealed the nurses ressings every three days by had both been applied to the h only one dressing was 0 p.m. R5 was observed seated he main dining room waiting tered nurse (RN)-D fed R5 the 0 wheeled R5 back to his room, n on and exited the room. mained in his wheelchair. NA)-D entered R5's room and h his hands and face and ital gown. R5 was not exited the room. R5 remained ntinued to watch television. and NA-A returned to the ed R5 from the wheelchair to air had a pressure cushion in place. R5's coccyx in intact thin Tegaderm ng. The skin along the edge of ep pink in color. A stated R5 was assisted out of nd confirmed R5 was not hours and 50 minutes. NA-A p NAs on staff, the staff were r could, however, they were assistance with timely	F 68	86				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245323	B. WING	;		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	directed by the care medical record, the of the exact date R signs of breakdown should have comple assessment when t DON stated she wa of the wound based - At 2:05 p.m. RN-E Duoderm dressing removal of the dress newly opened areas measured the first of to be 1.0 cm x 0.3 of the lower left buttoo cm. In addition, un three deep red app blanchable areas. changed appearance observed it. RN-D new and the wound - At 2:10 p.m. the D The DON stated the R5's sacrum, the sk intact. The DON co developed stage 2 partial thickness sk dermis, or both). R dressing over the u Review of R5's clinit days later) revealed related to the newly wound care and me On 3/23/18, at 9:30	 a plan. Upon review of the DON stated she was unaware b DON stated she was unaware b S unable stated the facility b eted a comprehensive skin he breakdown began. The sunable to determine the size l on the facility documentation. D was observed to remove a from R5's sacrum. Upon sing, RN-D identified two s under the dressing. RN-D b pen area on the left buttocks cm. The second open area on ks measured 2.0 cm by 2.0 der the dressing there were roximately one inch non RN-D stated the wound had b since the last time she had c stated the open areas were l ooked worse. ON observed R5's sacrum. e last time she had observed kin was dry and flaky but onfirmed R5 had newly ulcers (pressure ulcer in which in loss involving epidermis, N-D applied a Duoderm 	F	686			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	pressure ulcer and any type of docume assessment related identified on 3/21/13 treatment orders fo the ETAR indicated applied even though applied to the woun care plan had not b R5 had not received with the facility polid R18 had developed which had worsene complete a compre determine efficacy of failed to update the R18's Admission Re R18 had diagnoses impairment, stroke, muscle weakness, and obesity. R18's quarterly MD had severe cognitive extensive assist fro toilet use, and was for transfers and hy the time of assessm pressure ulcer and (Stage 3- Full thickn	the facility failed to complete entation or comprehensive d to the new pressure ulcers 8. RN-E verified R5 had two r the same sacral wound and l both dressings were being h only one dressing had been nd. RN-E also verified R5's been followed as directed and d wound care in accordance cy. d a pressure related ulcer to and the staff failed to shensive wound assessment to of current interventions, and e care plan. ecord dated 3/22/18, indicated a which included mild cognitive , hemiplegia, and hemiparesis, fatigue, venous insufficiency, S dated 3/2/18, indicated R18 ve impairment, required im 2+ staff for bed mobility and totally dependent on 2+ staff vgiene. The MDS indicated at nent, R18 had one stage 2 two stage 3 pressure ulcers ness tissue loss.	F 6	586	DEFICIENCY)		
	tendon or muscle a be present but does tissue loss. May inc tunneling) which me Ulcer treatments inc	nay be visible but bone, ire not exposed. Slough may s not obscure the depth of clude undermining or easured 2.0 x 6.0 x 0.4 cm. cluded pressure ulcer care, cing device for bed and					

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		AND HUMAN SERVICES					FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245323	B. WING				03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, Z	ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			BIRCHWOOD AVENUE WES	ST PO BOX 7	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPF	BE	(X5) COMPLETION DATE
F 686	Continued From pa wheelchair.	ge 56	F 68	36				
	indicated R18 was a ulcers, and had a h CAA further indicate mattress or seat cu pressure. The CAA	er CAA dated 8/22/17, at high risk for pressure istory of pressure ulcers. The ed R18 required a special ishion to reduce or relieve did not identify which type of nd/or seat cushion R18						
	required extensive bathing, grooming a extensive assist of mechanical lift. The "has pressure ulcer pressure ulcer area potential impairmen fragile skin, immobi pressure ulcers. Th	nted on 3/22/18, indicated R18 assist of one staff for dressing, and bed mobility, and two staff for transfers with a e care plan also indicated R18 rs development" related to as to the coccyx, and had a nt to skin integrity related to ility, weakness, and history of he care plan directed the staff illowing interventions:						
	-report abnormalitie maceration and sig physician -identify/document eliminate/resolve w -use a draw sheet of resident. -administer treatment for effectiveness	nd dry, apply lotion on dry skin es, failure of skin to heal, n/symptoms of infection to the potential causal factors and here possible or lifting device to move the ents as ordered and to monitor n to buttocks twice a day and						
	causes of skin brea transfer/positioning	ent/family/caregivers as to akdown including requirements, importance of ambulating/mobility, good						

Facility ID: 00995

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		CONSTRUCTION	(X3) DA1	. 0938-039 E SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG			IPLETED		
		245323	B. WING			03	27/2018		
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE				
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			9 BIRCHWOOD AVENUE WEST PO BO ALKER, MN 56484	(700	700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE		
F 686	Continued From pa	ige 57	F 68	86					
	nutrition and freque	ent repositioning.							
		nt of skin breakdown							
		sed treatment, confer with the plinary team and family to							
		try alternative methods to gain							
	compliance. Docun	nent the alternative methods.							
		ily/caregivers of any new skin							
	breakdown -lift sling to be remo	oved when in bed							
		if needed, every shift to ensure							
		d adhering. Report loose							
	dressing to treatme								
	monitor intake and	status. serve diet as ordered, record							
		/report, as needed, any							
		tus: appearance, color, wound							
		symptoms of infection wound							
	size, and stage. - obtain and monito	r lab work							
		ily importance of changing							
		evention of pressure ulcers							
		all frequent position changes							
	more often if neede	n R18 at least every two hours,							
		e relieving/reducing device on							
	bed/chair, however	, does not identify which type							
	of cushion to be us								
		ban in bed. encourage R18 to ninutes, observe skin and							
		or open areas to nurse							
	-weekly skin observ	vation. If open area, treatment							
		nclude measurement of each							
	type of tissue exuda	lown's width, length, depth, ate (drainage).							
	Although the care p	olan addressed pressure							
	ulcers, the care pla	n did not address the newly							
	developed pressure	e ulcers and/or was not revised							

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		245323	B. WING _			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7 ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	to reflect the pressu 3/2/18, MDS assess plan lacked identific reducing mattress r R18's Tissue Tolera 2/24/18, indicated F pressure ulcers with current or history of stroke, and was not The evaluation indic prominences was p sitting for one and t evaluation also ider position after 1/2 ho the skin over bony p blanchable. The evaluation after 1/2 ho the pink areas were repositioning sched R18's physician ord -Complete weekly s (start date 2/13/17) -wound evaluation of Monday per MD ord -Change Tegaderm moist wound bed) t days in the morning prep to coccyx befor prevent skin tears. 3/20/18) -Monitor Tegaderm upper buttocks eve is in place, dressing Dressing to remain 9/30/17)	ure ulcers identified on the sment. In addition, the care cation of the type of pressure required for R18's needs. Ance Observation dated R18 was at high risk for h risk factors that included f pressure ulcers, history of t cooperative with positioning. cated skin over bony bink and blanchable after wo hour time frames. The ntified when R18 was in a lying bur, one hour, and two hours prominences was pink and aluation did not identify where e and did not identify a lule. ders included: skin assessment on Mondays	F 68	36			
1		g 4x4 to sacral and buttock					

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		AND HUMAN SERVICES				FORM	: 05/04/2018 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION		E SURVEY IPLETED	
		245323	B. WING			03/	27/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKER	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 686	Continued From pa	age 59	F	586				
	-	ery 3 days until healed (start						
		wheelchair (start date 3/20/18)						
	(PN) reviewed form lacked completed of and consistency of ascertain locations	ws (WSR) and progress notes n 1/1/18, through 3/20/18, comprehensive evaluations documentation in order to , worsening, and or healing further lacked evidence of device efficacy.						
	mid coccyx slit, res and a patch was ap orders. -WSR dated 1/8/18 maceration, applied coccyx, had a sma -PN note dated 1/1 dressing placed to superficial, still very	8, Small pinpoint open area in t of area appears macerated, oplied per MD (medical doctor) 8, Open area, had areas of d patch per MD order to Il pinpoint area that is open. 4/18, included a hydrocolloid buttocks. Slit in coccyx was y fragile. One open area to left						
	areas on right butto -WSR dated 1/15/1 maceration on coco 1.0 centimeter (cm wound. Applied dre record lacked evide evaluation or ongoi -WSR dated 1/22/1	8, Continues to have cyx, has on upper right buttock) open area. Red around essing per MD orders. The ence of any further wound ng treatment. 8, Has maceration in gluteal						
	open area. On the wounds. Proximal i measures 0.5 x 0.5 applied Mepilex dre -PN dated 1/23/18,	indicated the MD was o open areas on buttocks and						

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	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
			A. BUILDI	NG				
		245323	B. WING			03	8/27/2018	
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	‹	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 686	Continued From pa	age 60	F 6	86				
		ordered placement of an						
	indwelling catheter							
	-WSR dated 1/29/1	18, continues to have on						
		6 millimeter (mm) open area						
		naceration to area. Dressing						
		x dried off. Will continue to						
	monitor.	I dated 1/29/18, indicated						
		g post indwelling catheter						
		efer to the weekly evaluation						
	for full description.	,						
		indicated the coccyx wound						
		ure ulcer and measured 1.0						
		depth of 0.5 cm with						
	duestionable tunne	ling in the center of the wound						
		ndicated the coccyx wound						
		and appeared to be a stage II.						
	No odor, redness,							
		3, coccyx 1.0 x 1.0 cm with 0.4						
		e associated. Able to visualize						
		allevyn thin to be applied and						
	changed every 3 da	ays. VD made aware of the						
	measurements of c							
		18, Coccyx very macerated and						
		one hour and turned to scabs.						
		hin pink skin area measures						
		epth superficial. Rest of coccyx						
		buttocks have 0.04 to 0.03 to						
		n dry scabs. With dry skin						
	attached around so	capped areas. 18, coccyx 1.0 x 0.4 cm purple						
		ot open at this time and left						
		bint 0.1 by 0.1 cm purple area.						
	Not open but surro							
	-WSR dated 2/26/1	18, center of coccyx measures						
		wound bed depth 0.4 mm,						
	areas of eschar 0.5	5 mm and slough (defined as						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· /	TE SURVEY MPLETED		
		245323	B. WING					
		245325		STREET ADDRESS, CITY, STATE, ZIP CODE	03	/27/2018		
NAME OF I	PROVIDER OR SUPPLIER				V 700			
WALKEF	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE		
F 686	••••••	-	F 686	3				
	thick and adherent present. Scant and odor present on dre wound. Other areas measure 2.0 cm x of -Corresponding PM director of nursing notified of the chan- -PN dated 3/2/18, i completed related of noted on coccyx 2. Stage 2 left of cocco 1.0 x 0.2 cm skin s Stage 2 right below 0.1 cm area. Sloug coccyx changed ev Offload side to side note indicated the of updated and an air 3/2/18. The note all historically refused an area to allow rep repositioning and s -WSR dated 3/5/18 3, no drainage app 0.2 x 0.2 cm scabb reddened. Left butt area, surrounding s resident non-comp repositioning from s cleansed and appli -WSR dated 3/12/1 circular, 0.03 mm of purple, other areas -PN dated 3/16/18,	ncluded: skin assessment was to skin breakdown. Stage 3 0 x 6.0 x 0.4 centimeters (cm). syx area approximately 1.0 x loughing off of the wound. v coccyx area, small 0.5 x 0.5 x h skin on top. Dressing to very three days and as needed. e positioning while in bed. The director of nursing was mattress would be placed on so indicated R18 had to offload (relieve pressure to perfusion to the skin) and taff would monitor. 8, 2.0 cm x 1 cm healing stage ears macerated. Left buttock wed area, skin around scab ock 2.0 cm x 2 cm scabbed skin white. Also included liant with turning and side to side. Larger areas						

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING	i		03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	be notified. -WSR dated 3/19/1 Wound bed 100% g cleansed and Derm 1.0 cm x 1.0 cm pre (Suspected deep tis localized area of dis filled blister due to o tissue from pressur be preceded by tiss boggy, warmer or c tissue. Evolution mad dark wound bed). Nappearance. Area o Left buttock has two x 0.2 cm. Present a Cleansed and appli On 3/19/18, at 11:44 her room, seated in cushion in the whee standard pommel c seating position and is made of dense for sliding out of the wh the bed was standar R18 stated she had bottom, had them for experienced discom R18 stated when st dressings she experiend indicated pain medit to the dressing char wanted an air mattr received one. R18 s wheelchair cushion R18 further stated s	 8, coccyx 1.5 x 1.0 cm. granulation tissue. Wound hallevyn applied. Right buttock esents as deep tissue injury ssue injury-purple or maroon scolored intact skin or blood damage of underlying soft re and/or shear. The area may sue that is painful, firm, mush, cooler as compared to adjacent ay include a thin blister over a lot open bruise like covered with Dermallevyn. o wounds- each measuring 1.0 as possible skin tears. ad Dermallevyn. 8 a.m. R18 was observed in the wheelchair. The seat elchair was identified to be a sushion (designed to stabilize d support hip alignment which bam to keep the resident from neelchair). The mattress on ard foam perimeter mattress. d pressure ulcers on her or a long time, and nfort when she sat too long. caff changed her wound erienced discomfort, however, ication was administered prior nges. R18 stated she had ress on her bed but had never stated did not think her had been changed/replaced. staff did not always reposition hey could probably offer to 	F	586			

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		AND HUMAN SERVICES				FORM	: 05/04/2018 APPROVED
		& MEDICAID SERVICES	<u></u>				. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED
		245323	B. WING			03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BO> VALKER, MN 56484	. 700	
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRC DEFICIENCY)	PRIATE	DATE
F 686	Continued From pa	ige 63	F 6	686			
		p.m. NA-B was observed to					
	full body mechanica	ner wheelchair into bed using a al lift. NA-B confirmed R18 had					
	bottom since 3/16/1	om but had not seen R18's 18, and stated somebody had					
	breakdown. NA-B p	dditional areas of skin bulled down R18's pants, which					
		colloid dressings positioned < and sacral/coccyx region,					
		uttock. NA-B stated the wound					
	unit coordinator (Hl	cal doctor (MD)-B and health JC) entered R18's room.					
	from the sores, to w	she had experienced pain vhich R18 responded she had					
		s MD-B removed the tacky marked she did not like this					
		cause it rips the skin. MD-B ids and verified the following:					
	-upper coccyx sacra stage 3)	al region stage 2, (healing					
	-left buttock open s	tage 2; the other wound below as superficial and "covered"					
	and because of tha	t was hard to stage.					
		the stage 2 ulcer were two eas and stated those were					
		om removing the adhesive					
		not considered pressure					
		ischium a small raised dark					
		rrounding redness. MD-B rea was necrotic tissue					
		ue to reduced blood supply)					
	and would be a stag	ge 2 when it opened.					
		ne inner right buttock Icral wound had shown					

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PRINTED: 05/04/2018

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245323	B. WING			03/;	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	improvement since catheter. MD-B ask been going to which well. MD-B reinforce to R18. R18 agreed further evaluation. N cushion was firm ar enough support and something more pro- stated R18 should h her bed in order to support while in bed had talked about pu- bed and was unawa implemented. On 3/22/18, at 7:57 pretty set routine ar repositioned every to but often refused. N repositioning, staff v of refusing such as stated she did not to because the resider repositioned 10-30 R18's mattress and changed and had a she currently used. -At 8:48 a.m. RN-D designated RN to p assessments, there whichever nurse wa RN-D stated skin as weekly, wound door include measurements	the insertion of an indwelling the insertion of an indwelling an R18 responded, not very ed importance of repositioning to go to the wound clinic for MD-B verified the wheelchair and flat and did not provide d should be changed to essure relieving. MD-B also have had an air mattress on provide more pressure relief d. HUC stated nursing staff utting an air mattress on the are why it had not been a.m. NA-B stated R18 had a and was supposed to be two hours from side to side, NA-B stated if R18 refused were to remind her of the risks skin breakdown. NA-B also hink there was enough staff nts were sometimes minutes late. NA-B confirmed I chair cushion had never been Iways been the same as what	F	\$86			

Facility ID: 00995

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	(X3) DA	TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` '	NG		MPLETED
		245323	B. WING _		03	/27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
WALKER	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484	3OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 686	causal factors of the implement appropri- stated if the pressu- the interventions she effectiveness and the and surfaces should effectiveness. -Continuous observention -Continuous observention -Continuous observention -At 11:30 a.m. R18 wheelchair, watching -At 12:04 p.m. NA-H room for lunch -At 1:03 p.m. an un returned R18 to here -At 1:08 p.m. R18 so not repositioned whe -At 12:49 p.m. RN-H Observations were comprehensive. RN should have been of measurements incli then staged, a com	e breakdown and evaluate and iate interventions. RN-D re wounds were not healing, nould be reassessed for he pressure relieving devices d also be assessed for vation from 11:30 a.m. until the following: was in her room, seated in the ng television. B wheeled R18 to the dining identified staff member r room. stated the staff member had hen returned to her room. E verified the Weekly Skin	F 68	36		
	new interventions, a RN-E stated the fac inconsistent with th difficult to ascertain with the skin. RN-E maintenance direct	terventions, implementation of and notification to physician. cility nurses were very eir documentation and it was exactly what was going on confirmed she had asked the or to put the air mattress on and thought it had been				

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	RN-E confirmed R1 foam mattress whice facility used, and was pressure ulcer/press indicated the only d was it had the edge -At 1:44 p.m. R18 r wheelchair. R18 station in the wheelchair un over at 2:00 p.m. R was over she would into bed. On 3/22/18, at 3:10 director confirmed s mattress on R18's H was waiting for a do stated she had not nursing staff for the so that she could pl bed. Although staff ident quarterly interdiscip- identified no behavion cares. Additionally, current on 3/22/18, care or individualized refusal of cares. R2's annual MDS d had severe cognitive which included Part and anxiety. The a required total assist	18's mattress was a standard ch all the residents in the as not provided based on her ssure relief needs. RN-E lifference on R18's mattress	F	586			

		AND HUMAN SERVICES			FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING		03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	Continued From pa	ige 67	F 686	5		
	R2 at risk for the de due to the inability t	r CAA dated 11/3/17, identified evelopment of pressure ulcers to reposition herself. The CAA ovide a redistribution cushion in bed.				
	10/31/17, indicated completed and iden development of pre clinical record did n Braden Scale. The not developed redd observation time. T	nce Observation form dated a Braden Scale had been ntified R2 at high risk for the essure ulcers, however, R2's not contain a copy of the observation indicated R2 had lened areas during the 'he observation tool did not cy of repositioning needs for				
	risk for the develop	ed 12/28/17, identified R2 at ment of pressure ulcers and assist R2 with a repositioning				
	7:05 a.m. to 10:00 a be assisted with rep - At 7:05 a.m. R2 w wheelchair in her ro - At 7:37 a.m. the H room to the dining r - At 7:41 a.m. the H with breakfast. - At 8:07 a.m. R2 ha HUC wheeled R2 o - At 8:12 a.m. R2 w - At 8:57 a.m. R2 w room by the activity - At 9:53 a.m. NA-B	vas observed seated in a bom. HUC wheeled R2 from her room. HUC served and assisted R2 ad finished the meal. The but of the dining room. vas wheeled back to her room. vas wheeled into the activity				

Facility ID: 00995

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		AND HUMAN SERVICES			FORM	: 05/04/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245323	B. WING		03/	/27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484)X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 686	assist/reposition he - At 10:00 a.m. NA- and assisted R2 to to the bed via a full pressure redistribut seat of her wheelch changed R2's incor pink and intact. -At 10:05 a.m. NA- assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos 2 hours and 30 min On 3/22/18, at 2:58 to be assisted with repos R23's Pressure Ulcr assist R23 with offic needed. R23's Braden Scale Sore Risk dated 3/2	 Provide the staff to utilize a mattress, chair cushion, and to be chance that the staff to utilize a mattress, chair cushion, and to cushion was noted on the hair. Once in bed, NA-B the cushion was noted on the hair. Once in bed, NA-B the cushion cushion was noted on the hair. Once in bed, NA-B the cushion cushion was noted on the hair. Once in bed, NA-B the cushion cushion was noted on the hair. Once in bed, NA-B the cushion cushion was noted on the hair. Once in bed, NA-B the cushion cushion was noted on the hair. Once in bed, NA-B the cushion cushion and to cushion was noted on the hair. Once in bed, NA-B the cushion, and to coading every two hours are plan. 	F 68	36		
	needed. R23's Braden Scale Sore Risk dated 3/9	e for Prediction of Pressure				

Facility ID: 00995

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245323	B. WING_			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	200	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	ulcers.	-	F 68	86			
		ce Observation Tool dated 23 did not develop reddened rs in one position.					
		ed 7/19/17, directed staff to ning every two hours.					
	7:13 a.m. to 10:07 p receive assistance - At 7:13 a.m. NA-B transfer R23 from b body mechanical lif - At 8:46 a.m. R23 p room. - At 8:48 a.m. R23 p	and NA-C were observed to bed to a wheelchair via a full					
	room for church.	was wheeled to the activity was wheeled from the activity					
	- At 10: 05 a.m. NA to transfer R23 from a full body mechani redistribution cushid wheelchair seat. R - At 10:10 a.m. NA- had not received as	was wheeled to his room. -B and NA-C were observed n the wheelchair to the bed via					
	On 3/23/18, at 10:3 to receive assistand hours as directed b						
	Superior Healthcare	e Management Minnesota					

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PRINTED: 05/04/2018

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED	
		245323	B. WING		03	03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	E		
NALKER	REHABILITATION &	HEALTHCARE CENTER		9 BIRCHWOOD AVENUE WEST PO B ALKER, MN 56484	3OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 686	Continued From pa	age 70	F 686				
	Risk Assessment of following: -pressure ulcers ar resident remained extended period of pressure or decreat -if pressure ulcers at discovered, they cat infected -pressure ulcers ar continual pressure, substances on the soap, discharge), of hydration status, ac resident's physical -pressure ulcers ar the resident -routinely assess a the resident's skin care program for a irritation or breakdo -Skin would be ass	are not treated when an become larger, painful, and e often made worse by , heat, moisture, irritating resident's skin (feces, urine, lecline in nutrition, and cute illness or decline in the and/or mental condition e a serious skin condition for nd document the condition of per facility wound and skin my signs and symptoms of own. essed for the presence of re ulcers on a weekly basis or					
	Region policy and p Treatment dated 12 guidelines and stra stage III pressure u consistent assess implementation of a monitoring for effic	e Management Minnesota procedure, Pressure Ulcer 2/23/17, included general tegies for stage I, stage II, and ulcers which directed nent and documentation, appropriate interventions, and acy of interventions, and n interventions based on					

If continuation sheet Page 71 of 250

		AND HUMAN SERVICES	1			FORM	05/04/2018 APPROVED 0938-0391
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:						E SURVEY PLETED
		245323	B. WING	i		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO		TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 70 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From pa	ge 71	F	688			
	resident who enters range of motion dour range of motion unic condition demonstrio of motion is unavoid §483.25(c)(2) A resimution receives ap services to increase prevent further decives \$483.25(c)(3) A resimution services appropriat assistance to main the maximum praction reduction in mobility This REQUIREMENT by: Based on observation review, the facility for motion services as the decline in range 2 of 5 residents (Resident of the services resulted in development of upp actual harm for R2 contractures in the facility failed to assesservices for 1 of 5 r limitations in ROM	acility must ensure that a the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range			This Plan of Correction constitutes written allegation of compliance for t deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law. 1. It is the policy of the facility to er resident do not have decline in ROM unless anticipated by clinical condition developed contractures of lower extremities and R5 developed contractures of upper extremities. Fe entered building dependent and defi limitations of ROM, had been in ther	the sion r that of nd nsure <i>I</i> on. R2 R5 inite	
	Findings include				and was discharged with braces and		

Facility ID: 00995

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	· /	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	700	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	1/10/18, indicated F impairment and dia Parkinson's disease depression. The M assistance of two s and all activities of functional limitation upper and lower ex MDS dated 9/1/17, upon staff for all ac bilateral functional I and lower extremitie R5's Activities of Da Assessment (CAA) required total staff a living related to end damage or malfund weakness. The CA participating in ther R5's Therapist Prog dated 9/14/17, indic contractures of the The physical therap complete upper and motion exercises in	num Data Set (MDS) dated R5 had moderate cognitive gnoses which included e, quadriplegia and DS indicated R5 required total taff for bed mobility, transfers daily living, and had bilateral in range of motion of the tremities. R5's admission indicated R5 was dependent tivities of daily living and had imitation in ROM of the upper es. ally Living Care Area dated 9/6/17, indicated R5 assistance all activities of daily ephalopathy (brain disease, tion), spinal fusion and A indicated R5 was	F 6	88	ROM to be done twice a day ROM to be done twice a day ROM to been completed and has had d decline per family and staff. R2 wa to have a request from therapy for to lower extremities and they had n been implemented. After survey no decline a review of ROM was comp Therapy orders both residents rece assist with splinting and exercises. changed to PROM with upper extre- in AM with cares, elbow splints, has splints on at night, boots in bed. R2 have PROM to extremities with hs teddy bear for transfers for arms, a boots on at night. Care sheets and plans updated, therapy consult in p 2. Because all residents have pot for decline or improvement all are potentially affected by the cited def decline in ROM triggers have been documentation has been reviewed interventions for prevention are in p and documented clearly on care pl Passive ROM to be completed with in morning and at night, and staff u DON or MDS nurse on any new de All current residents have been ass for decline during comprehensive assessment along with appropriate interventions. Therapy has comple baseline screens of all residents'; s	efinite s noted PROM ot oted the oleted, eived to R5 emities nd 2 will cares, ind care olace. ential iciency, pulled, place ans. cares pdate cclines. sessed eted all	
	provide gentle rang On 3/19/18, at 10:1 stated she was not type of range of mo R5's arms began to	bility and directed the staff to e of motion with daily cares. 5 a.m. family member (FM)-A aware of R5 receiving any tion services. FM-A stated o contract one year ago after esulted in R5's quadriplegia.			reviewed on 5/2/18 to assure comp of all residents. Implementation of interventions is reviewed in IDT. St alert DON is resident refuses other No other residents were affected. T policy on ROM has been updated. 3. To enhance currently complian operations and under the direction	those aff to wise. ⊺he t	

Facility ID: 00995

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	• •				PLETED
		245323	B. WING _			03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX /ALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 688	Continued From pa	ge 73	F 68	88			
	FM-A stated R5 had the accident, howey therapy services sir was to wear his bra were getting worse. observed seated in elbow braces on. Th inner aspect of the extended to the mid were covered with a secured with velcro prevented further fle R5's elbows were in hands rested in a fis - At 12:40 p.m. NA- residents and only t to all the residents of shifts. One NA wor stated the NAs were with basic cares but services. NA-C sta provided during the however, they [NAs complete the exerci- On 3/20/18, at 12:3 room, seated in a w braces on. NA-B sta straighten/extend h move them a few in move his shoulders approximately 1-2 in - At 5:55 p.m. NA-D with evening cares.	d received therapy right after ver, had not received any nee that time. FM-A stated R5 ces daily, but felt R5's arms At this time, R5 was a wheelchair with bilateral he braces were applied to the left and right elbows and d upper and lower arms and a soft cloth padding and straps. The braces exion of the elbows. In a fixed position, and his sted position. C stated the facility had 23 two NAs to provide direct care during the day and evening ked on the night shift. NA-A e able to provide the residents t did not provide ROM ted ROM exercises were to be provision of morning caress,] did not have to time ises. 7 p.m. R5 was observed in his vheelchair, with bilateral elbow ated R5 was not able to fully is arms rather was only able to oches. R5 was observed to a which also moved his arms			director of nurses, on 5/1/2018 all received in-service training on RO monitoring declines. The training emphasizes the importance of foll all interventions for effective preverse contractures. Education also done importance of comprehensive assessment of ADL □ s, contracture implementation of appropriate interventions. 4. Effective 4/23/2018, a quality-assurance program was implemented under the supervision director of nurses to monitor resid changes in ROM and updating ME and care plans with any changes the ensure appropriate follow through director of nurses or designated quality-assurance representative with the therapy department will do bas screens on all residents starting 5. this will create a baseline for RON will monitor in PCC that extremitie maintaining movement in upper are extremities q shift. MDS nurse will all residents audited daily for splin changes in ROM x 5d. Then 4 res weekly for 4 weeks to ensure committee meeting for further revisor the monthly quality-assurance committee meeting for further revisor the further revisor further r	M and owing ention of on es and n of the ents for), family o . The vill hanges: seline /2/2018 I. Staff s are nd lower I ensure ting and idents ents pliance s. Any ne spot, urance ubmitted	

CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (M) PROVIDERUPUERCLUID (A) DENTFICATION NUMBER (A) DENTFICATION NUMBER (A) DATE SUPPLY (A) DATE SUPPLY <t< th=""><th></th><th></th><th>AND HUMAN SERVICES</th><th></th><th></th><th></th><th>FORM</th><th>05/04/2018 APPROVED 0938-0391</th></t<>			AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WALKER REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE WALKER, NN N5643 STREET ADDRESS, CITY, STATE, ZIP CODE CHOP ENCLOYED SUMMARY STATEMENT OF DEFICIENCES CHOP ENCLOYED FORMARY STATEMENT OF DEFICIENCES CHOP ENCLOYED PROVIDERS PLANK OF CORRECTION F 688 Continued From page 74 elbow moving it slightly in order to remove R5's shift sleeved. F 688 that wo inches away from R5's body resulting in NA-D maneuvering his shift sleeved bits arm. F 688 NA-A Slipped the shift over R5's head and slid it off of the left arm. R5's head and slid it off of the left arm. R5's head and slid it off of the left arm. R5's head and slid it off of the left arm. R5's head and slid it off of the left arm. R5's head and slid it off adgree angle. R5's right hand fingers appeared fixed with NA-D only washing between his fingers. NA-A gain washed R5's left arm as not observed to provide R5's and as an is hand was open with his fingers suched to a 45 degree angle. R5's right hand fingers appeared fixed with NA-D only washing between his fingers. A-At 6:16 p.m. NA-D stated the evening shift staff did not provide the residents' any ROM exercises because the day shift staff odi not provide the residents' any ROM exercises because the day shift staff odi and provide the residents' any ROM exercises hoe and reassigned to provide the residents' any ROM exercises hoe and reassigned to provide the reables hordoces and reassigned to provide the residents' functional maintenance program as a stabiblished by the physical therapi	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY
WALKER REHABILITATION & HEALTHCARE CENTER 209 BIRCHWOOD AVENUE WEST P0 B0X 700 WALKER, NN 5643 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MS 18 PPRECEEDE BY FULL TAG PROFINITION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (POI) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 688 Continued From page 74 elbow monig it slightly in order to remove R5's shint sleeve. While lifting the elbow, his arm was unable to extend and his shoulder moved less than two inches away from R5's badd resulting in NA-D maneuvering his shint sleeve off his arm. NA-A slipped the shint over R5's shint sleeve. While the shint was removed. NA-D proceeded to wash R5's hands and arms. When washing the hands, R5' was noted to extend his right fingers to an approximately 90 degree angle. R5's right hand fingers appeared fixed with NA-D only washing between his fingers. NA-D again washed R5's left hand as his hand was open with his fingers extended to a 45 degree angle and were unable to extend any further. NA-D completed the cares by dressing R5 in a hospital gown and applying loton to R5's arms, elbows and shoulders. NA-D was not observed to provide R5 any upper extremity ROM exercises. On 3/21/18, at 9:19 a.m. NA-C stated she had been the NA assigned to provide the residents' any ROM exercises because the day shift staff did not provide the residents' any ROM exercises because the day shift staff did not provide the residents' mony as established by the physical therapist. However, in February 2018, she was removed from rehab services, and reassigned to provide resident personal cares. NA-C stated R5 had had a functional maintenance program in the past, how were, now that there is not a specific employee assigned to provide resident personal cares. NA-C stated R5 had			245323	B. WING	i		03/:	27/2018
WALKER REHABILITATION & HEALTHCARE CENTER WALKER, MN 56484 [PAU]ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST REPRESEND BY FULL REGULATIONY OR LSC DENTEYING INFORMATION) PROVIDER SUM OF CORRECTION ECONNECTION (EACH OBRECED TO THE APPROPRIATE DEFICIENCY) OWALKER, MN 56484 F 688 Continued From page 74 elbow moving it slightly in order to remove R5's shift sleeve. While lifting the elbow, his arm was unable to extend and his shoulder moved less than two inches away from R5's body resulting in NA-D maneuvering his shift sleeve of this arm. NA-A slipped the shift over R5's hands and arms. When washing the hands, R5's mands and arms. When washing the hands, R5's mands and arms. When washing the hands, R5's mands and arms. NA-D again washed R5's left hand as his hand was open with his fingers extended to a 45 degree angle and shoulders. NA-D was not observed to provide the cares by dressing R5 in a hospital gown and applying lotion to R5's arms, elbows and shoulders. NA-D was not observed to provide the residents' any ROM exercises because the day shift staff did not provide the residents' any ROM exercises because the day shift staff completed the ROM programs/exercises. - At 6:16 p.m. NA-D stated the evening shift staff did not provide the residents' any ROM exercises because the day shift staff completed the ROM programs/exercises. - At 6:16 p.m. NA-C stated she had been the NA assigned to provide the residents' functional maintenance program as established by the physical therapist. However, in February 2018, she was removed from relab services, the NAs were	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
Preferx TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE CONTINUED TO THE APPROPRIATE CONTINUED TO DEFICIENCY) F 688 Continued From page 74 elbow moving it slightfy in order to remove R5's shirts leeve. While lifting the elbow, his arm was unable to extend and first should moved less than two inches away from R5's bands and arms. When washing the hands, R5 was noted to extend his right fingers to an approximately 90 degree angle and were unable to extend any further. NA-D completed the cares by dressing R5 in a hospital gown and applying lotion to R5's arms, elbows and shoulders. NA-D was not observed to provide R5 should the R0M programs/exercises. - At 6:16 p.m. NA-D stated the evening shift staff did not provide the residents' any ROM exercises because the day shift staff completed the ROM programs/exercises. - At 6:16 p.m. NA-D stated the ROM programs as established by the physical therapist. However, in February 2018, she was removed from rehab services, RM Pab Services and reassigned to provide the resident personal cares. NA-C stated R5 had had functional maintenance program in the past, however, now that there is not a spec	WALKER	REHABILITATION &	HEALTHCARE CENTER				' 00	
elbow moving it slightly in order to remove R5's shirt sleeve. While lifting the elbow, his arm was unable to extend and his shoulder moved less than two inches away from R5's body resulting in NA-D maneuvering his shirt sleeve off his arm. NA-A slipped the shirt was refis head and slid it off of the left arm. R5's left arm was not observed to move while the shirt was removed. NA-D proceeded to wash R5's hands and arms. When washing the hands, R5 was noted to extend his right fingers to an approximately 90 degree angle. R5's right hand fingers appeared fixed with NA-D only washing between his fingers. NA-D again washed R5's left hand as his hand was open with his fingers to an approximately 90 further. NA-D completed the cares by dressing R5 in a hospital gown and applying lotion to R5's arms, elbows and shoulders. NA-D was not observed to provide R5 any upper extremity ROM exercises. - At 6:16 p.m. NA-D stated the evening shift staff did not provide he residents' any ROM exercises because the day shift staff completed the ROM programs/exercises. On 3/21/18, at 9:19 a.m. NA-C stated she had been the NA assigned to provide the residents' functional maintenance program sa established by the physical therapist. However, in February 2018, she was removed from rehab services and reassigned to provide resident personal cares. NA-C stated R5 had had a functional maintenance program in the past, however, now that there is not a specific employee assigned to provide the relabs services, the NAs were	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
provision of personal cares. NA-C stated the staff	F 688	elbow moving it slig shirt sleeve. While I unable to extend ar than two inches aw NA-D maneuvering NA-A slipped the sh off of the left arm. I observed to move w NA-D proceeded to When washing the extend his right fing degree angle. R5's fixed with NA-D only NA-D again washed was open with his fi degree angle and w further. NA-D comp R5 in a hospital gow arms, elbows and s observed to provide exercises. - At 6:16 p.m. NA-D did not provide the because the day sh programs/exercises On 3/21/18, at 9:19 been the NA assign functional maintena by the physical ther 2018, she was remy reassigned to provide maintenance progra that there is not a s provide the rehab s directed to provide	 a.m. NA-C stated she had hed to provide the evening shift staff completed the ROM so. b. stated the evening shift staff residents' any ROM exercises and approximately so to provide the residents' and applying lotion to R5's houlders. NA-D was not exclusional applying lotion to R5's houlders. NA-D was not explicit staff residents, any ROM exercises and the evening shift staff residents any ROM exercises and the provide the residents and applying lotion to R5's houlders. NA-D was not exercises and the evening shift staff residents any ROM exercises and the evening shift staff residents any ROM exercises and the provide the residents' any ROM exercises and the provide the residents and the provide the	F	5888			

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STATE BURNOR OF CORRECTION (M3) PROVIDERSUPPLIERCIAN DEVENOR CONFECTION (M3) DATA (M3) DATA (M3) DATA (M3) DATA (M3) DATA COMPLETED (M3) DATA COMPLETED COMPLETED (M3) DATA (M3) DATA <td< th=""><th></th><th></th><th>AND HUMAN SERVICES</th><th></th><th></th><th></th><th>FORM</th><th>05/04/2018 APPROVED 0938-0391</th></td<>			AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WALKER, REHABILITATION & HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE OWIND TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCEDED BY FULL RECOLATORY OR LSC DENTFYING INFORMATION) D PROVIDER'S LAW OF CORRECTION OF CORRECTION (EACH DEFICIENCEDED BY FULL RECOLATORY OR LSC DENTFYING INFORMATION) PROVIDER'S LAW OF CORRECTION (EACH DEFICIENCY MUST BE PROVEDED BY FULL RECOLATORY OR LSC DENTFYING INFORMATION) PROVIDER'S LAW OF CORRECTION (EACH DEFICIENCY) F 688 Continued From page 75 simply did not have the time to provide ROM services in addition to routine personal cares. F 688 ON 321/18, at 9:21 p.m. licensed practical nurse (LPN)-B confirmed RS had not been receiving ROM services and stated due to this, it had been getting more difficult to apply RD'S ellow braces because his arms were more stiff and his contractures were getting tighter. F 688 -A1 9:30 a.m. registered nurse (RN)-D stated she could not recall RS even having received range of motion services and confirmed the braces were more difficult to apply due RS's increased stiffness of his upper extremities. Review of RS's electronic Medication and Treatment Administration Record dated 3/2018, indicated the nursing staff were to apply hand braces at hight and elbow braces during the day. The records did not direct the staff to perform range of motion services was to be completed with personal cares. The DON stated she was not aware the exercises were not being completed as directed. - A1 1:10 p.m. the regional director of clinical services (RDCS) stated the facility did not have a restorative program, however, they had recently hired a new company to provide physical th	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /		E CONSTRUCTION	(X3) DATE	E SURVEY
WALKER REHABILITATION & HEALTHCARE CENTER 29 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, NN 5643 OMULT PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FAG III PREFIX REOULTORY OR USCIDENTFYING INFORMATION) III PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTINUE DEFICIENCY F 688 Continued From page 75 simply did not have the time to provide ROM services in addition to routine personal cares. F 688 On 3/21/18, at 9:21 p.m. licensed practical nurse (LPN)-B confirmed R5 had not been receiving ROM services and stated due to this, it had been getting more difficult to apply R5s elbow braces because his arms were more stiff and his contractures were getting tighter. F 688 -A1 9:30 a.m. registered nurse (RN)-D stated she could not recall R5 even having received range of motion services and confirmed the braces were more difficult to apply due R5's increased stiffness of his upper extremities. Review of R5's electronic Medication and Treatment Administration Record dated 3/2018, indicated the nursing stiff were to apply hand braces at night and elbow braces suff and elbow braces during the day. The records did not direct the staff to perform range of motion services for R5. - A1 1:05 p.m. the director of nursing (DON) stated range of motion services was to be completed as directed. - A1 1:05 p.m. the regional director of clinical services (ROCS) stated the facility did not have a restorative program, however, they had recently hired a new company to provide physical therapy to the residents. The RDCS stated she was unaware R5's braces were more			245323	B. WING			03/2	27/2018
WALKER REHABILITATION & HEALTHCARE CENTER WALKER, NN 56484 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE REFECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) OWNETTION (CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) OWNETTION (CROSS-REFERENCE) OWNETTION	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
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 simply did not have the time to provide ROM services in addition to routine personal cares. On 3/21/18, at 9:21 p.m. licensed practical nurse (LPN)-B confirmed RS had not been receiving ROM services and stated due to this, it had been getting more difficult to apply R5's elbow braces because his arms were more stiff and his contractures were getting tighter. -At 9:30 a.m. registered nurse (RN)-D stated she could not recall R5 ever having received range of motion services and confirmed the braces were more difficult to apply due R5's increased stiffness of his upper extremities. Review of R5's electronic Medication and Treatment Administration Record dated 3/2018, indicated the nursing staff were to apply hand braces at night and elbow braces during the day. The records did not direct the staff to perform range of motion services were not perform range of motion services were not being completed with personal cares. The DON stated she was not aware the exercises were not being completed as directed. - At 1:10 p.m. the regional director of clinical services (RDCS) stated the facility did not have a restorative program, however, they had recently hird a new company to provide physical therapy to the residents. The RDCS stated she was unaware R5's braces were note difficult to apply due to decreased movement. The RDCS stated 	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
therapy.	F 688	simply did not have services in addition On 3/21/18, at 9:21 (LPN)-B confirmed ROM services and getting more difficul because his arms w contractures were g -At 9:30 a.m. registe could not recall R5 motion services and more difficult to app stiffness of his uppe Review of R5's elect Treatment Administ indicated the nursin braces at night and The records did not range of motion ser - At 1:05 p.m. the di stated range of moti completed with pers she was not aware completed as direct - At 1:10 p.m. the re services (RDCS) st restorative program hired a new compart to the residents. Th unaware R5's brace due to decreased m R5 would need to b	 the time to provide ROM to routine personal cares. p.m. licensed practical nurse R5 had not been receiving stated due to this, it had been It to apply R5's elbow braces were more stiff and his getting tighter. ered nurse (RN)-D stated she ever having received range of d confirmed the braces were only due R5's increased er extremities. ctronic Medication and tration Record dated 3/2018, ng staff were to apply hand elbow braces during the day. t direct the staff to perform rvices for R5. lirector of nursing (DON) tion services was to be sonal cares. The DON stated the exercises were not being ted. egional director of clinical cated the facility did not have a n, however, they had recently ny to provide physical therapy he RDCS stated she was es were more difficult to apply 	F 6	88			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245323	B. WING	;		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	On 3/21/18, at 3:10 therapy assistant (F evaluated by physic abilities had not bee On 3/22/18, at 2:46 had provided the re the past and stated knowledgeable staf a resident had a de R2's annual MDS d had severe cognitiv which included Parl and anxiety. The N extensive staff assis living, total staff assis functional limitation: Daily Living CAA did annual assessment R2's ROM abilities of quarterly MDS date functional limitation: extremities. R2's Assessment of dated 1/13/18, indic limitations of ROM extremities. R2's care plan date to monitor and repor provide physical the needed, and to mor signs or symptoms contractures formin R2's clinical record	p.m. the contracted physical PTA)-A stated R5 had not been cal therapy, therefore his ROM en assessed. p.m. RN-E confirmed NA-C sidents' restorative services in NA-C would be the most f member who could identify if cline in ROM ability. ated 11/2/17, indicated R2 re impairment and diagnoses kinson's disease, dementia IDS also indicated R2 required stance for all activities of daily sist for transfers, and had no s in ROM. The Activities of d not trigger at the time of the t, therefore an assessment of was not conducted. R2's d 12/27/17, indicated R2 had s in bilateral upper and lower f Functional Range of Motion cated R2 had bilateral in the upper and lower	F	688			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		E CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245323	B. WING			03/:	27/2018
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7	'00	
	1			W	/ALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From pa	ge 77	F 6	88			
	R2's Restorative Re R2 had received pa (PROM) to the bilat times per week, and five times a week. The February 2018 R2 had received R0 extremities on 11 da documentation end blank from 2/15/18 2018, documentati On 3/21/18, at 11:3 assist R2 with chan During the cares, R disconnected requi changed. While ch noted to be unable knees. NA-C stated assigned to assist F the middle of Febru reassigned to assist cares instead of co stated R2 used to b to about 50% full ex longer being provid knees had become NA-C proceeded to of pants. -At 11:35 a.m. NA-C hands were held in her left shoulder an however, the right s than two inches and her arm at the elbor	ecord dated 1/2018, indicated ssive range of motion eral lower extremities five d PROM to upper extremities , Restorative Record indicated DM to the upper and lower ays, however, the ed on 2/14/18. The record was - 2/28/18, and the March on was blank. 0 a.m. NA-C was observed to ging an incontinent brief. 2's colostomy bag ring R2's clothing to be anging R2's pants, R2 was to straighten her legs at the d she had previously been R2 with ROM exercises but in ary 2018, she had been t with residents' with routine mpleting ROM services. NA-C re able to straighten her knees tension, but since she was no ed ROM exercises, R2's tighter/more contracted. assist R2 with applying a pair					

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PRINTED: 05/04/2018

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	hand opened to app NA-C confirmed R2 extremities, however ROM ability had nor stopped. NA-C sta ROM exercises dur since the facility had for the 23 residents time to complete R0 - At 3:10 p.m. PTA- evaluated by physic determine if service R2's clinical record documentation relation in ROM exercises. On 3/22/18, at 2:45 to be receive assist directed by the care completed the ROM therefore she would the facility who coul ROM had occurred licensed nurses had evaluating the ROM determine if the ress services, evaluating for a change in a re stated the NAs were with morning cares any pertinent charg charge nurse and th document the ROM administration record	degree angle and the left proximately a 75 degree angle. 2 had limitations in her upper er, stated R2's upper extremity t changed since the ROM had ated the staff were to complete ring morning cares, however, d only two NAs to provide care of, the staff did not have the OM exercises, as directed. A stated R2 had not been cal therapy in order to es were needed. lacked any type of ted to R2's ability to participate of p.m. RN-E confirmed R2 was cance with PROM exercises as e plan. RN-E stated NA-C had A services in the past, d be the only staff member in ld truly identify if a change in . RN-E confirmed none of the d been monitoring or A program in order to idents were receiving the g their progress, or monitoring esidents' ROM ability. RN-E e to complete ROM exercises and were directed to report e in a residents' ability to the he nurses were directed to	F	5888			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/:	27/2018
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	provided. RN-E correflect a ROM prog motion in her lower R23's quarterly MD had severe cognitiv which included dem aphasia (inability to R2 required extens activities of daily liv 10/13/17, indicated assistance for all ac R23's care plan dat to have physical the therapy evaluate ar physician. The car to report signs and contractures formin plan did not direct t ROM exercises. R23's Therapist Pro Summary dated 4/1 extremity limitations therapist indicated in R23's Therapist Pro Summary dated 4/1 extress was not i R23's Therapist Pro summary dated 4/1 limitation in ROM in occupational therap receive ROM exercises	onfirmed R2's record did not ram and verified R2 range of extremities had declined. S dated 3/9/18, indicated R23 ve impairment and diagnoses nentia, history of stroke and o speak). The MDS indicated ive assistance with all ing. R23's annual MDS dated R23 required total staff ctivities of daily living. ted 7/19/17, directed the staff erapy and occupational nd treat R23 as directed by the re plan also directed the staff symptoms of immobility, or ng or worsening. The care he staff to assist R23 with ogress and Discharge 13/17, indicated R23 had lower s in ROM. The physical nursing staff was to provide nual stretches including s. The frequency of the indicated. ogress and Discharge 14/17, indicated R23 had in the upper extremities. The pist indicated R23 was to cises however, the frequency	Fé	588			

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OMB NO. 0938-0391
ULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
IG 03/27/2018
STREET ADDRESS, CITY, STATE, ZIP CODE
209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484
D PROVIDER'S PLAN OF CORRECTION (X5) FIX (EACH CORRECTIVE ACTION SHOULD BE IG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
* 688

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688 F 689 SS=K	had limitations in Re restorative program recently started with verified R23 had no needed due to his le The Range of Motio 12/23/17, directed to residents' joints and directed the staff to ROM had been reco order, the staff were physician to obtain addition the staff were physician to obtain addition the staff were following in the resident - The date and time - The date and time - The name of the p - The type of ROM - Whether the exere - How long the exere - If and how the res procedures or any of ability to participate - Any problems or of residents related to - If the resident refut why along with inter Free of Accident Ha CFR(s): 483.25(d)(1) \$483.25(d)(1) The r as free of accident for	5 p.m. RN-E confirmed R23 OM and did not have a current A. RN-E stated that facility had a new therapy provider and t been evaluated for services eff sided limitations. On Exercises policy dated he staff to exercise the d muscles. The policy also verify a physician order for eived and if there was no e to contact the attending an order, as needed. In ere directed to record the dent clinical record: of the exercises. Derson providing the exercise. exercises. cise was active of passive. cise was conducted. ident participated in the changes in the resident's complaint made by the the procedure. used the treatment and reason ventions taken. azards/Supervision/Devices 1)(2)		588			5/6/18

Facility ID: 00995

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TEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI		3) DATE S	
D PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPL	ETED
		245323	B. WING			03/27	7/2018
AME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	-	(X5) COMPLETIO DATE
F 689	Continued From pa	ge 82	F 6	89			
		sistance devices to prevent					
		NT is not met as evidenced					
		vation, interview and			This Plan of Correction constitutes m		
		he facility failed to identify,			written allegation of compliance for the		
		ssess, implement interventions ision for 1 of 1 resident (R226)			deficiencies cited. However, submissi of this Plan of Correction is not an	ion	
		eeking behavior and had			admission that a deficiency exists or t	that	
e C ir		ility twice without the			one was cited correctly. This Plan of		
	completion of an as				Correction is submitted to meet		
	implementation of i	nterventions to ensure his			requirements established by state and	d	
		systematic failure resulted in			federal law.		
		ious harm, injury, impairment			1. It is the policy of the facility to ass		
		s with exit seeking behavior			residents are free of accident hazards		
	immediate jeopardy	ent. This failure resulted in an			R226 was noted to have had multiple instances or exit-seeking and was		
					successful eloping one night – staff di	id	
	The IJ for R226 bec	gan on 12/3/17, at 5:40 a.m.			not promote safety by putting	i u	
		on 3/21/18, following an			interventions in place to keep from		
	elopement from the				elopement. This resulted in IJ which w		
		ed R226 to the facility. R226			reduced to SS=D and facility has now		
		e facility and began displaying			revised and educated on elopement p		
		ors and eloped from the sions without staff identifying,			and procedures and taking all residen statements seriously if they are exit	IL	
		ementing immediate			seeking. Educated on care plans,		
		6/21/18, at 10:01 a.m. the			assessments and safety devices. R22	26	
		tor of nursing (DON),			had already been discharged and follo		
	registered nurse (R	N)-E, and the regional director			up was to teach staff about elopemen		
		(RDCS) were informed of the			policy. R14 had cervical fracture r/t fal		
		oved on 3/27/18, at 12:00 p.m.			and no comprehensive assessments		
		liance remained at a scope			completed no interventions for safety		
	potential for more the	solated no actual harm with			were addressed and this resulted in a which was reduced to SS=D on	IIIJ	
					3/27/2018. R14 had fall assessment		
	2. Based on observ	ation, interview and document			completed, bed raised to level of safe	;	
	review, the facility facility facility	ailed to comprehensively			transfers for resident to stand safely, i		
		ent interventions in order to r serious injury, impairment or			removed, and resident walks twice a c for strengthening. Elopement assess		

Facility ID: 00995

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL		(X3) DATE	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COM	PLETED
		245323	B. WING _			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 70 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 689	Continued From pa	ae 83	F 68	39			
1 009	death for 1 of 2 res for falls. R14 was a neck) fracture and without the complet assessment and im This failure resulted The IJ began for R and identified on 3/ fall. R14 was requi which wrapped aroi connected to a thor (TLSO) stabilizing b the back and abdor fracturein 1/18. Th interventions to mir 3/22/18, at 1:10 p.n RN-E, and the RDC The IJ was remove however, noncomp and severity of D - potential for more th 3. Based on obser document review, ti comprehensively as mechanical lift in or serious injury, impa- resident (R2) who c when transferred w implement interven This resulted in an R2's IJ began on 9/	idents (R14) reviewed at risk dmitted with a cervical (high continued to fall at the facility tion of a comprehensive uplementation of interventions. If in an IJ for R14. 14 on 3/6/18, at 11:00 a.m. 22/18, when R14 sustained a red to utilize a cervical collar und R14's neck and was racic lumbar sacral orthosis orace which wrapped around men due to a cervical e facility failed to implement mize/prevent further falls. On n. the DON, administrator, CS were informed of the IJ. d on 3/27/18, at 12:00 p.m. liance remained at a scope isolated no actual harm with han minimal harm. vation, interview and he facility failed to identify and ssess the use of a full body der to minimize the risk for inment or death for 1of 1 obtained repeated skin injuries ith the lift and failed to tions to prevent further injury.		39	as well. R2 sustained s/t during trans assumed to be caused by however, report or investigation completed, no comprehensive assessments completed and reduced on 3/27 to SS=D. R2 no uses a teddy bear to hold during trans and helps hold arms in position from self-bruising during transfers, lift assessment in place, skin monitored weekly and skin assessment completed R8 was noted to have syncopal type episodes and one was noted during of sit to stand which potentially could led to injury this was found to be an which was reduced on 3/27 to SS=D was noted to not have been assesses Hoyer sling size or safety, BP monito being monitored by physician and hypertensive medications have beer reduced. PT also worked with R8 an give her some exercises to do which allows occasionally but since medicat reduction has been stronger, lift assessment completed, fall assessm and medication review completed. R had no smoking assessment or comprehensive assessment to show smoking capabilities. R13 had smok assessment and deemed safe to sm independently. In this case, after the surveyors tagged the building and no these deficiencies, immediate updat were made on abuse preventions,	no bewed in IJ ow nsfers n d eted. e use d have IJ D. R8 ed for oring n d did n she ation ment {13 v safe king noke e oted	
	being transferred in The facility failed to risk for injury despit	a full body mechanical lift. comprehensively assess the te additional injuries sustained rred in the lift, and implement			investigations, incident and accident elopement procedures and safe care with comprehensive assessments completed for all residents that resid	es	

Facility ID: 00995

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		DEITH IO/(HON NOMBER.	A. BUILDII	NG		0011	
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 689	Continued From pa	age 84	F 68	89			
	interventions in ord further injures. The notified of the IJ on IJ was removed on however, noncomp and severity of D - potential for more t 4. Based on observed document review, t comprehensive sta assessment in order to minimize the risk or death for 1 of 1 n experienced synco standing lift without assessment and ec competency on its R8. The IJ began for R documentation reve episode while utilizi lift. Subsequent inter previous syncopal utilizing the lift with comprehensive ass syncopal episode e use of the lift and e 3/22/18, at 12:08 p and RDCS were no removed on 3/27/1 noncompliance rem	er to minimize the risk for administrator and DON were 3/22/18, at 12:00 p.m The 3/27/18, at 12:00 p.m. Jiance remained at a scope isolated no actual harm with han minimal harm. // ation, interview, and he facility failed to complete a nding mechanical lift er to determine it was safe and a for serious injury, impairment resident (R8) who had pal episodes while utilizing a t the completion of an ducate and assess staff use. This resulted in an IJ for 8 on 3/9/18, when ealed R8 had a syncopal ing the standing mechanical erviews revealed R8 had episodes prior to 3/9/18, while out the completion of a sessment in order to determine toology, to continue the safe educate staff on its use. On .m. the administrator, DON, otified of the IJ. The IJ was 8, at 12:00 p.m. however, nained at a scope and severity ctual harm with potential for			in the facility. The policy on smokin assessments, mechanical lifts, falls incidents and accidents were review and updated. R8 care plan was upd with Hoyer assessment and sling information, R13 had smoking assessment completed, R14 has be assessed for falls, R2 has had Hoye assessed and care planed. Staff ha been educated on all situations and aware of necessity follow up. 2. Because all residents live in this community where accidents are pose and not always avoidable all are potentially affected by the cited defin All residents that smoke will be asse on admission, quarterly and annual with significant change for smoking All residents that require mechanicat have been assessed and appropria slings chosen based on manufactur recommendations. Care plans and sheets are updated. All residents th have a fall, bruise or skin tear will h- incident report and full investigation completed and reported to DON an agency as necessary by regulations resident shat make statements wanting to leave or are exit seeking interventions in place and care plan accordingly. No other residents wer affected. Currently all residents are current with assessments and follow 3. To enhance currently compliant	wed lated een er we l are s care ssible ciency. essed ly or safety. al lifts te rers care lat ave d state s. A bed; view. of have ined re	
						of the ve	

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245323	B. WING	;		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 70	00	
				V	VALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	iae 85	F	689			
	Elopement:			000	federal requirements for incidents,		
					accidents, elopement risks, mechan		
	R226's Admission F indicated R226's dia	Record form dated 3/21/18,			lifts, smoking assessment needs an need for an environment free of haz		
		norrhage, wedge compression			The training emphasizes the importa		
	fracture of the lumb	par vertebrae, muscle			documentation, notification, assessi		
		onic embolism and thrombosis			and care planning.		
	of the deep veins in	i the left leg.			4. Effective 4/24/2018, a quality-assurance program was		
	R226's Clinic Healt	h Status form dated 11/13/17,			implemented under the supervision		
		Elopement question #6 was			ED and DON to monitor residents w		
		" which indicated R226 had nt move in a room or facility.			falls, bruises, Hoyer's, smoking, and incident r/t the environment. The D	-	
		is section indicated for any			designated quality-assurance		
		'yes" the rater should consider			representative will perform the follow		
		f care for elopement. Section ad intermittent confusion.			systematic changes: randomly chec residents who are approved to	king	
		ed a comprehensive			self-administer. The DON or design	ee will	
	elopement assessn				complete 2 audits per week x 4 wee	eks,	
	Doocle admission N	Amine Deta Sat (MDS)			then 1 audit weekly x2 months on al	1	
		Vinimum Data Set (MDS) icated R226 had moderate			residents that smoke to ensure assessment complete and on Hoyer	r lifts	
		nt, had no behaviors including			to ensure assessed and care planne		
		uired extensive assistance of			correctly. Safety checks on fall and		
		obility, transfers, dressing, unit, toileting, and personal			elopement risks 4 residents per wee weeks, then 2 residents weekly for 2		
		also indicated R226 required			months. Any deficiencies will be cor		
	limited assistance of	of one staff for walking in room			on the spot, and the findings of the		
		comotion on the unit. In			quality-assurance checks will be	بالعرم	
	believed he was ca	ndicated R226 and the staff			documented and submitted at the m quality-assurance committee meetir		
		some of the aforementioned			5. The ED and DON will be respon		
	activities of daily liv				for this POC.		
	R226's 14 day MDS	S dated 11/27/17, indicated					
	R226 had moderate	e cognitive impairment, had no					
		cluded wandering, and					
	required limited sta	ff assistance for all ADLs.					

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	R226's baseline ca indicated R226 had able to communicat of falls. The behavior R226 was unhappy discharging in the fri interventions section restraints section in initiated 12/3/17. R226's care plan da self care performant intolerance, lumbant fractures, and fatigut gastrointestinal blead plan directed staff t Physical and occup R226 with a goal to function in ADLs ind plan also indicated related to decondition and history of falls p related to the lumband directed staff to addr to monitor the impant cognition. The care frequent elopement elopement. Review of R226's p the following: -PN dated 11/13/17 was admitted to the oriented with some note at 10:10 p.m. in out asking where here	re plan dated 11/13/17, I intermittent confusion, was te verbally, and had a history or concerns section indicated of at the facility but would be uture. The behavioral on was blank. The alarms and ndicated a wanderguard was ated 12/8/17, indicated an ADL nee deficit related to activity of thoracic compression ue related to a recent ed, and deconditioning. The o assist R226 with ADL needs. bational therapy was treating of improve current level of cluding ambulation. The care R226 was at high risk for falls oning, gait/balance problems prior to admission. Acute pain ar/thoracic fractures and minister pain medication and tet of the medication on R226's e plan failed to identify R226's t attempts and risk for progress notes (PN) revealed of a fally and was alert and confusion noted. An additional indicated R226 was hollering e was and had been walking with a walker, several times	F	589			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DA). 0938-039 TE SURVEY MPLETED		
				IG				
		245323	B. WING _		•	/27/2018		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE				
WALKEF	R REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE		
F 689	-PN dated 11/15/17 oriented to person, confusion, especia required assistance ambulation with a v independently. -PN dated 11/17/18 intermittent confusi where he was at. N from staff for transf self independently -PN dated 11/18/17 oriented to self with increased as the da -PN dated 11/19/17 started hollering ou facility. -PN dated 11/21/17 time confusion and transfers, utilized a distances when usi -PN dated 11/26/18 be more confused out of his room yell R226 did not know -PN dated 11/28/17 have confusion ear family and did not k Redirected easily. -PN dated 12/3/17, between 5:00 a.m. about going home. go home when wal there was a bus to	7, indicated R226 was alert and but was having periods of lly during the night shift. R226 e of one staff for transfers and valker but had been doing this 8, indicated R226 had fon in the evening not knowing leeded occasional assistance fers and had been up wheeling in the wheelchair. 7, indicated R226 was alert and n some confusion which ay progressed, 7, at 4:24 a.m. R226 had it and was trying to leave the 7, indicated R226 had night was independent with walker and propelled self long ing the wheelchair. 8, indicated R226 continued to in the evening. Would come ing and looking for people.	F 68	39				

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILLI	IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY		
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG		MPLETED		
		245323	B. WING_		03	8/27/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	O BOX 700	OX 700		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 689	Continued From pa	ge 88	F 6	39				
	him. A facility and g and staff were unal called to report the the police department had an elderly gent R226 was returned temporary wanderg every 15 minutes c was scheduled to the following Friday (12 facility Minnesota In 12/3/17, at 7:30 a.m 12/5/17, was a cop and also indicated would update R226 care plan was not the elopement risk or a implemented to pre- -PN dated 12/3/17, was very confused hallucinations and the to visit on and off a applied 9:30 a.m. the elope. -PN dated 12/3/17, was having increase use call light anyment assistance. Became evening and roament wanderguard place from the facility dur on his own and also -PN dated 12/7/17, during the evening, make needs known Daughter was called	ground search was conducted ble to locate R226. 911 was missing resident at which time ent informed the facility they deman at their department. to the facility at 6:30 a.m A guard was applied to R226 and hecks were initiated. R226 ransfer to an assisted living the 2/8/17). A corresponding neident Report form dated n. with a revision date of y of the above progress note the registered nurse (RN) b's care plan. However, R226's updated to include the additional interventions to be event further elopements. at 6:03 p.m. indicated R226 during the shift with noted paranoia. Family had been in Il shift. Wanderguard was b alert staff of attempts to at 10:00 p.m. indicated R226 ded bouts of confusion. Did not bre to summon staff e more confused during the ed around the facility. Had a d tonight due to his elopement ing earlier hours. R226 walked o used a wheelchair. indicated some confusion and would use call light to n. Was wanting to go home. d and was able to calm R226. valking and able to propel self						

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	the facility to an ass On 3/20/18 at 1:41 review the facility al procedures related administrator and D to locate it within the - At 1:49 p.m. the R resident left the fac to leave, or unwitnet that is was an elope would notify family f them, they would ca department to see if would also search the -At 4:25 p.m. the ac RDCS confirmed, b R226 had eloped fr unaware of any pre R226's clinical reco previous elopement due to their recent of had no knowledge of about the facility's a related to elopement RDCS stated the w "revamped." The ac and the DON starte aware of the failure educating the staff program policies an elopement.	p.m. when requested to buse prevention policy and to elopement, the DON stated they were unable e facility. RDCS stated anytime a ility without a physician's order essed, it would be assumed ement. Therefore, the facility to see if the resident was with all the local policy/fire if they had found anyone, and	F 6	89			
	stated if a newly ad elope from the facil applied to the resid	mitted resident attempted to ity, a wanderguard would be					

Facility ID: 00995

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PRINTED: 05/04/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
WALKER	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7 ALKER, MN 56484	200	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	more than one occa attempted to leave "always caught him him. NA-A also sta facility had not only rather on all shifts." 12/3/17, elopement R226 had a wander had not alarmed to facility. -At 6:30 p.m. cook (happy about being a from the facility a co incident with the po only time R226 had leave the facility. C- which occurred "wa department incident pick up R226 after I down town at a gas street from the polic "somebody" had ca the staff that one of however, "somebood	d. In a sign prior to 12/3/17, R226 the facility, however, staff had " by the door and redirected ted his attempts to leave the occurred on the night shift, When asked about the , NA-A stated she thought rguard in place, however, it alert staff of him leaving the (C)-A stated R226 was not at the facility and had eloped ouple of times. C-A stated the lice department was not the gotten away or attempted to A recalled another incident	F 64	89			
	stated R226 used a had to get downtow the middle of the str of the road that had snow fall. C-A reme appropriately dress temperature. On 3/21/18 at 8:31	a.m. NA-B confirmed R226 be there and stated he had					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF PROVIDER OR SUI	PPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
WALKER REHABILITAT	ION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX VALKER, MN 56484	700	
PREFIX (EACH DEF	ICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
through any of NA-B stated R226 until aff the police stat to leave the f stated she way where R226 NA-B stated facility, the N nurse the need not apply one -At 8:38 a.m. resident who made it to the incident where back to the fa dementia the LPN-B stated admission pa care planning wanderguard would go up t taken care of applied. -At 10:01 a.m the RDCS we elopement as had eloped fr the facility by administrator confirmed the On 3/26/18, a voiced a desi the facility un	pted to door the the water the active as not actuall if a response As cou- ed for a witho LPN-I had e e police e "son actility. refore a she cou- the cha to ense a desc on the an un perwor a desc on the an un perwor a desc an un perwor a desc a de	ge 91 o get out and leave the facility iat was in his site at the time. nderguard was not placed on incident where he had went to ven though he had attempted prior to that. However, NA-B aware of any other incident y eloped from the facility. sident attempted to leave the ald "highly" suggest to the a wanderguard, but they could ut their direction. B stated she remembered a loped from the facility and had e station and also the first nebody" had brought R226 She also stated R226 had could not leave unsupervised. Id not complete any resident ever, if a resident needed a o exit seeking behaviors, she ain of command and get it sure a wanderguard was administrator, DON, RN-E and ormed of R226's first ribed by C-A in which R226 e building and was returned to identified person. The , RN-E and the RDCS e all unaware of this incident. p.m. NA-B stated if resident I had also attempted to leave <i>v</i> ised, the staff were to inform a well as all other staff,	F 6	89			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	• • • • • • • • • • • • • • • • • • • •	-	F€	689			
	the nurse would ap	ve minute visual checks, and ply a wanderguard to alert was attempting to leave the					
	3/27/18, at 12:00 p. the following: - conducted an elop residents. - developed and im and procedures rela and safety which in of comprehensive a of interventions and requirements. - staff education reg policy and procedur - A quality assurand implemented in ord	n on 12/3/17, was removed on .m. when the facility completed beenent risk assessment on all plemented improved policy ated to resident elopement cluded the timely completion assessments, implementation d supervision, documentation garding the updated/revised res. ce program was also ler to monitor all incidents and e no safety hazards or safety					
	Assessment dated admitted to the faci diagnoses which in fracture of the seve routine healing, hig diabetes, and late of	Irsing Home Admission 1/23/18, indicated R14 was lity on 1/19/18, and had cluded a closed, nondisplaced enth cervical vertebra with h blood pressure, type II onset moderately advanced e with behavioral disturbance.					
	R14 had moderate sustained a fracture admission, required	DS dated 1/26/18, indicated cognitive impairment, had e as a result of a fall prior to d limited assistance for bed and ambulation of one person					

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II -	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED	
		245323	B. WING		03	8/27/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 689	and required extens for activities of daily incontinent of bowe displayed any inapp R14's Falls Care An triggered for further not completed, as r comprehensive fall completed. On 3/20/18, at 12:4 resting in bed. R14 his neck connected orthosis (TLSO) sta around the back an low to the floor (app floor) and a one ind side of the bed. R1	age 95 sive assistance of one person y living, was frequently el and bladder, and had not propriate behavior symptoms. rea Assessment (CAA) had r assessment, however, it was required. Therefore, a risk assessment had not been 88 p.m. R14 was observed had a cervical collar around to a thoracic lumbar sacral abilizing brace which wrapped ad abdomen. R14's bed was proximately 12 inches off of the ch thick fall mat was on each 4 did not have a call light er to summon assistance, if asked about the events which	F 6				
	however, R14 was sequence of events and could not verba the nursing home of R14 appeared to ha surveyor and was r speech was difficul was continuously o whereas he had sle On 3/20/18, from 5 continuously obsert seated in a wheeld light within reach. A observation, did the room to observe R	the to the nursing home unable to articulate the s which led to his admission, alize how long he had been in or where he was living prior. ave difficulty hearing the not wearing hearing aids. R14's t to hear and understand. R14 bserved until 1:49 p.m. ept off and on, in bed. :54 p.m. to 6:48 p.m. R14 was ved to be remain in his room, hair. R14 did not have a call At no time throughout the e facility staff stop in R14's 14 for safety. During the ad removed his tennis shoes, tempt to transfer					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTION	ICIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245323	B. WING		03/	27/2018
NAME OF PROVIDER OF	≀ SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABILI	TATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
PREFIX (EACH	DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
 slept off a At 7:18 p and was a the TLSO (approximone inch t) bed. R14 summon a completed On 3/21/1 the dining positioned actively w were on to not provid assistance tennis show On 3/22/1 dress, how Following room. -At 8:25 a room and observed Review of following i admissi was admit following a a TLSO b confusion 	ently. Thr and on whi o.m. R14 v assisted to b.the bed nately 12 i thickness was not p assistance d. 18, at 9:00 proom and d in front of vatched a op of R14 ded a call e. R14 was bes. 18, at 8:02 wever, dic cares, N/ n.m. R14 p sat in his to sleep of f R14's me informatio ion note d the fall with orace and n. R14 req	roughout the observation, R14 ile seated in the wheelchair. was provided evening cares o bed. R14 continued to wear was in a low position inches from the floor) and a fall mat was placed next to the provided a call light in order to e, if needed, when cares were 0 a.m. R14 was wheeled out of d assisted to his bedroom and of the television where he program. R14's hearing aids 's bedside stand, and R14 was light in order to summon as wearing the TLSO, and 2 a.m. NA-C assisted R14 to d not insert his hearing aids. A-C wheeled R14 to the dining propelled himself back to his wheelchair. R14 was off and on while in the chair. edical record revealed the	F 689			

Facility ID: 00995

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		AND HUMAN SERVICES			FORM	: 05/04/2018 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245323	B. WING		03/	27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	(700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	incontinence. - PN dated 1/20/18, information: R14 w and family only, had hard of hearing, and needs. R14 was no urinary incontinence and was assisted to R14 required assist not ambulating, and distance travels. R1 for all activities of d himself independen history of wandering injury. R14 had nun- skin tears from prev- placed in low position on both sides of be- discomfort, and phy occupational therap started per MD order - PN/Skin Assessminis injures as such: forearm, top of rightantecubital, large bu- left hand, right inne- lateral and medial area entire left side of far top of head, over 5thand, and left lateral noted above left eye ear, and skin tear to R14's clinical recordance R14's clinical recordance Review of R14's cardinered the staff:	, indicated the following vas alert and orientated to self d marked confusion, was very d had difficulty expressing of able to utilize call light, had e, wore incontinence briefs, o the toilet every two hours. tance of one for transfers, was d used the wheelchair for long 14 required assistance of one laily living and was able to feed ntly after tray set-up. R14 had a g and a history of falls with nerous bruises, abrasions, and vious falls. R14's bed was on and fall mats were placed d. R14 denied pain or ysical therapy and by (PT&OT) services were er. ment dated 1/20/18, described a numerous bruises - right t hand, right elbow, right ruise to left outer thigh, top of er buttocks, bruising to both ankle, and yellowing bruising ice. R14 had scabbed areas to th and 4th knuckles of left al forearm. Lacerations were e with steri strips intact, left o left elbow.	F 689			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY IPLETED
		245323	B. WING			03/:	27/2018
NAME OF PROVIDER OR SUF	PLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABILITAT	ION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	'00	
PREFIX (EACH DEFI	ICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
assistance. - Educate the safety remind fall occurs. -Encourage [I promote exer activity for str - Ensure that footwear whe -Follow facility - Pt [physical ordered or PF R14's fall incli 3/22/18, durin falls one on 3 1. R14's PN c today while si was reaching sustained skin measuring 1 o [right] 2nd km elbow 1 cm L of these were Bacitracin app mark to his he fall. VSS. neu D.O.N. [direct family, Dr [do denies pain a monitor." R14's Inciden had a fall at 1	e reside e as no ppt reside ders ar R14] to rcise, p rengthe [R14] to rcise, p rengthe [R14] to rcise, p rengthe [R14] to rank y fall p l thera RN [as dents ng which b/6/18, dated (itting in p for so on tears cm [ce uckle 1 , sl. b e clean plied a ead th uros [n tor of n botor] a at this t	dent to use it. eeded. sponse to all requests for ent/family/caregivers about nd what to do if a o participate in activities that ohysical ening and improved mobility. is wearing appropriate oulating or mobilizing in w/c. protocol. (py] evaluate and treat as	F 68	9			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	out of the wheelcha comprehensive ass not been completed identified R14's beh level, underlying illn reaching for to asse concern. The report to the bathroom at indicated to minimiz should not be left in down, however, this added to R14's card above observations leave R14 alone in wheelchair. 2. R14's PN dated 3 "staff walking past r his knees over the f [wheelchair] facing Was unwitnessed. I an previous skin tea middle knuckle area adherent dressing a kerlix. DON notified at 9:30 a.m." R14' incident report, no p completed and ther implemented to mir On 3/22/18, at 8:25 not to be left in his n was resting in bed of common areas. RN medication cart clos she was able to che stated the facility fa	nightstand. R14 fell forward	F	589			

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		& MEDICAID SERVICES	1				0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	· /	E SURVEY PLETED	
		245323	B. WING			03/2	27/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
NALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	T PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 689	Continued From pa	age 98	F 6	89	9			
	further intervention	s not able to articulate any s. RN-D looked for a facility ever, she was unable to locate						
th ir w w	they were unaware interventions for R was allowed to be i	5 a.m. NA-B and NA-C stated of any type of fall 14. The NAs confirmed R14 n his room unattended and ny type of special monitoring						
	interviewed regardi and policies/ proce arrival at the facility a facility falls policy obtained a corpora facility staff to use s confirmed the facili on keeping R14 sa RDCS stated when not been comprehe factors, however, a developed which in been left in his roor confirmed the facili the intervention, an R14's care plan. Th had not been comprisks after the fall th	a.m. the RDCS was ing the facility's fall program, dures and stated upon her on 3/20/18, she could not find and procedure, therefore te policy and procedure for starting on 3/21/18. The RDCS ty falls program was ineffective fe from ongoing falls. The R14 fell on 3/6/18, the fall had ensively assessed for causal on intervention had been included R14 should not have m alone. However, the RDCS ty staff had not implemented and it had not been added to be RDCS also confirmed R14 prehensively assessed for fall hat occurred on 3/11/18, in usal factors and implemented intions.						
	RDCS was notified immediate jeopard to the facility failure) p.m. the administrator and that R14 was identified in y to his health and safety due to comprehensively assess, ment fall interventions to keep						

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		AND HUMAN SERVICES			FORM	05/04/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	R14 safe from fall in time the administra developing a remove R14's safety related 3/22/18, at 1:10 p.m unattended. R14 has as a result of the fa RDCS stated that F one staff supervision interventions and pl developed and impl The immediate jeop was removed on 3/ facility implemented included the followin - Completed a com R14. - Updated R14's can how to arrange the - R14's bed was plather height to allow R14 - R14 received a ph - Developed an impl procedure regarding interventions follow - Staff members we to R14's plan of car prevention policy. Mechanical Lifts: R2's annual MDS d had severe cognitive which included Part and anxiety. The a	ncidents. However, during the tor and RDCS were val plan which addressed d to falls R14 fell yet again on n. while R14 was in his room ad not suffered a major injury II. On 3/22/18, at 2:01 p.m. the R14 would be provided one to on until appropriate lans for safety could be lemented. bardy that began on 3/6/18, 27/18, at 12:00 p.m. after the d a removal plan which ng: prehensive fall assessment for re plan to direct the staff as to height of R14's bed. aced in a standard level bed to enter/exit the bed safely. hysical therapy assessment. olemented a policy and g falls and immediate	F 689			

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING _			03/:	27/2018
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	activities of daily liv assistance of two s R2's Lift Mobility St indicated R2 did no weight on his/her le tolerate a semi-recl was to be transferred name of a full body the form was incom not been assessed sling or the number transfer R2 with the R2's care plan date impaired mobility re progression. The p transfer R2 with ass body mechanical lif staff to use caution mobility in order to arms, legs and han surfaces. On 3/20/18, at 7:44 residents who requ transfers could be t of one or two staff of comfortable the stat the lift. On 3/21/18, at 12:0 resting in bed. NA- sling under R2 and lift. RN-C was prese RN-C did not assist the bed via the full NA-C utilized the lift	ing and required total taff for all transfers. atus form dated 12/31/17, it have the ability to bear egs. R2 had the ability to lined position and indicated R2 ed with a MaxiMove (brand mechanical lift). The rest of nplete, as it was blank. R2 had to identify the appropriate size of staff members required to	F 6	89			

Facility ID: 00995

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED
		245323	B. WING		03/27/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	DX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 689	sling. When the lift R2's feet repeatedl support beam. NA assistance in order hitting the support l continue with the tr positioned over her acknowledged R2's the hydraulic beam feet away from the the wheelchair. On 3/22/18, at 10:0 her room, seated in the room and proce transfer R2 from th body mechanical lift feet were observed lift. NA-B did not re another staff to ass proceeded to place Review of R2's inci following information - An incident report transfer lift with hoy Resident left forear resident not grabbi tear was received." was identified as let the area was clean was applied. The the size of the skin lacked documentat a root cause analys	t sling was in a seated position, y bumped the hydraulic -C did not ask RN-C for to protect R2's legs from beam as she proceeded to ransfer. When NA-C had R2 wheelchair, RN-C s feet were repeatedly bumping and assisted by holding R2's bar as NA-C lowered R2 into 00 a.m. R2 was observed in a wheelchair. NA-B entered eeded to independently e chair to the bed via a full ft. During the transfer, R2's I to rub against the hydraulic equest assistance from sist with the transfer and e R2 into bed.	F 68	39		

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING_			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER	-		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From partransfer which resured - An incident report "Resident has very hand from resident transfer resident where ident not to grab during transfers. Ju- indicated R2 sustain the right hand. The Bacitracin was apple with the dressing. indicate the size of information on the re- the use of the mech to chair and vice ver motion, R2 would be lift which resulted in reassured R2 and re- lift in those areas, be lift. The lift was una "these parts" from re- documentation did staff members press and interventions in prevent/ minimize fre- completed. - An incident report aide noted a 0.6 cm left hand webbing s cm bruise after usin bleeding noted. Re- the lift while mid tra- pinched." The would.	sc IDENTIFYING INFORMATION) age 102 Ited in injury. dated 10/29/17, read: small skin tear to top of right grabbing the lift used to nile in motion. Staff reminds o lift but continues to do so ust a little pink." The report ned a skin tear of the back of a area was cleansed, lied and the area was covered The documentation did not the skin tear. Additional report indicated R2 required hanical lift to transfer from bed area. When the lift was in hang on the moving parts of the n skin tears. Staff members reminded her not to grab the but R2 continued to grab the able to be stopped to prevent moving during transfers. The not address the number of sent at the time of the injury nplemented in order to urther injuries was not dated 11/15/17, read: "Nurse n [centimeter] skin tear in the surrounded by a 2.0 cm x 2.0 ng the mechanical lift. No esident has a tendency to grab unsfer on the moving parts. It ind was cleansed, Bacitracin			CROSS-REFERENCED TO THE APPROPI		DATE
	injury was noted to hand. The report i	applied. The location of the be on the back of the left dentified the cause of the erventions implemented in					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		O	RINTED: 05/04/2018 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
245323 B	B. WING		03/27/2018
NAME OF PROVIDER OR SUPPLIER		TREET ADDRESS, CITY, STATE, ZIP CODE	
WALKER REHABILITATION & HEALTHCARE CENTER		09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
 F 689 Continued From page 103 order to prevent further injuries was not completed. The number of staff members present at the time of the injury was not identified. Further review of R2's clinical record lacked documentation related to the aforementioned injuries. Nor was a comprehensive assessment related to transfers via a mechanical lift documented. On 3/22/18, at 11:50 a.m. the RDCS confirmed the facility did not have any further documentation related to R2's injuries and the number of staff members present at the time of the injuries was unknown. RDCS confirmed no interventions were implemented to minimize R2's risk for additional injuries. At 12:08 p.m. the RDCS, administrator and DON were notified of the IJ related to R2's transfers with a fully body mechanical lift. At 2:46 p.m. RN-E confirmed R2's care plan directed the staff to transfer with assist of two staff members. RN-E verified the injuries were from the mechanical lift, however, upon further review of R2's clinical record, RN-E confirmed the record lacked any additional documentation related to the injuries. On 3/24/18, at 8:21 a.m. R2 was observed in her room, seated in a wheelchair. NA-B was observed to connect R2 to a fully body mechanical lift and independently transferred R2 from the wheelchair to bed. During the transfer, R2 folded her hands as she was lifted into the air and her feet/shoes rubbed up against the hydraulic support beam during the transfer. No additional staff members were present at the time 	F 689		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COM	PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa of the transfer.	ge 104	F 6	89			
	On 3/27/18, at 11:10 observed to transfe from the bed to the blanket under R2's under R2's left arm, during the transfer to the mechanical lift. The immediate jeop was removed on 3/2 facility implemented included the followin - Completed a comp assessment for R2. - Updated R2's care as to how to safely to mechanical lift. - Developed and im procedure regarding residents while utiliz - Staff were educate standing lift policy a care plan. R8's Admission Reg R8 had diagnoses w	prehensive transfer/lift e plan to direct the care staff transfer R2 with a the full body plemented a policy and g the safe handling of zing a full body lift. ed on the changes to the is well as changes to R2's					
	weakness, and non treatment or regime R8's quarterly MDS had intact cognition assistance from one	sential hypertension, muscle -compliance with medical en. dated 1/22/18, indicated R8 , required extensive e staff member for transfers, hygiene, and had impaired					

		AND HUMAN SERVICES			FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	E SURVEY PLETED
		245323	B. WING		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX NALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 105	F 689			
	record on 3/21/18, i assistance with four assist for toilet use. R8 had impaired con non-compliant with update dated 3/22/ use of a sit to stand R8's PN dated 1/26 buckled during a tra- made to physical the transfers using a m periods of weakness R8's Physical Thera Treatment dated 2/ referred for evaluat evaluation included included: failure to the arthritis, seizures, d muscle weakness. had lower extremity to bear weight. The (PT)recommended transfers with the us stand lift. R8's clinical record evaluation which we sling size and how t	apy Evaluation and Plan of 9/18, indicated R8 was ions of safe transfers. The history and risk factors which thrive, hypokalemia, falls, liabetes, hypertension and The evaluation indicated R8 weakness, and was not able physical therapist that R8 should perform all se of the mechanical sit to lacked a mechanical lift ould identify an appropriate many staff were needed to when using the sit to stand				
	to include the PT re Mobility Status tool which indicated R8 lift. The tool read: "	e care plan also lacked revision ecommendation. The only Lift on record was dated 11/18/17, did not require a mechanical This is only a guide and circumstances and medical				

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		AND HUMAN SERVICES			FORM	: 05/04/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245323	B. WING		03/	/27/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484	OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	conditions. Only a tr and therapy or qual involvement will crep patient and staff, wh increasing mobility a R8's PN dated 3/9/ ⁷ had "passed out" we lunch. R8 complain large amount of inc would up updated. It vital signs (heart rat saturations) were of episode. Historical blood pre- from R8's record or 2/21/18-123/64 2/27/18-105/58 3/1/18-96/55 3/8/18- 89/55 3/12/18-86/48 R8's clinical record notification of the ph blood pressure read not evident any mea assessments or mo- ensure safe transfe despite the hypoten "passing out" during at high risk for injury R8's Physical Thera Treatment dated 3/ referred related to r out" in the sit to stat	eam approach with nursing lified medical personnel eate the safest situation of the hile meeting the goal of and improving patient health." 18, indicated a NA reported R8 hile in the stand-up lift after ed of nausea at the time, had continent stool and the doctor R8's record lacked evidence te, blood pressure, oxygen btained after the syncopal essures viewed and copied n 3/21/18, revealed:	F 689			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	r			APPROVEI . 0938-039
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		245323	B. WING		03/	/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484	OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	had reported, "pass week for 15-20 sec lift. The evaluation having medications therapist recomment mechanical lift for a to R8 and staff. R8 documentation of th occurred during me However, this PT re- implemented. Fax communication 3/12/18, at 11:30 a. pressure was 86/48 last three times pe she had not been a morning and indica orthostatic hypoten indicated R8 had lo months and perhap blood pressure meet responded, and gat blood pressure meet pressure daily for s with blood pressure R8's record lacked full body lift assess recommendation, a documentation of n symptoms related t and/or evaluation o lowered doses of b Blood pressures ob	sing out" two to three times per onds when in the sit to stand indicated nursing discussed reviewed. The physical hded the use of the full body ill transfers to prevent injuries s clinical record lacked he syncopal events which echanical lift transfers. ecommendation was never to the physician dated m. indicated R8's blood 8. The note indicated over the 8 had periods of passing out at er week. The writer explained ware of the episodes until that ted an awareness of sion at night. The writer further st 30 pounds in the past six is not tolerating the doses of dications. The physician we orders to decrease both dications and check blood even days and to update her a readings and symptoms. a completed comprehensive	F 6	89		

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		AND HUMAN SERVICES <u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MI II I			FORM MB NO	05/04/2018 APPROVED 0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	l` í				IPLETED
		245323	B. WING			03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX VALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 108	F 6	89			
	dated 3/14/18, india PT recommendation mechanical lift for t sit to stand lift woul resident wanted toi agreed that a full be cause decrease in therefore the physic were discontinued. lacked evidence of potential risks which impairment or deat mechanical lift was safety by the PT. On 3/21/18, at 12:4 and stated she had obtained the sit to se explained it was he facility and had not R8 directed RN-C H around her and how mechanical lift. One R8, and connected to tighten the harne R8 informed RN-C during lift transfers.	ted during the time of survey cated nursing discussed the ins for the use of full body ransfers. Per resident request, d be utilized for transfers as leting independence and ody mechanical lift would her dignity and ability to toilet cal therapy recommendations However, R8's clinical record R8 being provided with the h included serious injury, h as well as the benefits if the not used as recommended for 22 p.m. R8's call light was on to use the restroom. RN-C stand mechanical lift and r second day on the job at the used a mechanical lift before. how to put the lift harness w to connect it to the ce the harness was around to the lift, R8 instructed RN-C ess, and to use the calf strap. of her history of passing out . RN-C informed R8 that she wait for R8's blood pressure to					

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION). 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· ·			MPLETED
		245323	B. WING _		03	/27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	ige 109	F 68	39		
	her wheelchair. The	e harness became very loose				
		however, RN-C continued with sitioned R8 on a nearby				
		C stated she had not received				
		use of the mechanical lift and				
		een the first one she had ever				
		tated mechanical lifts could be o people and was dependent				
		RN-C stated she did not know				
		ss should be when using a sit				
	to stand lift.	g				
		cal therapy assistant (PTA)-A				
		company he worked for was				
		as of 1/26/18. PTA-A stated				
		ents for safe transfers on				
		y, and if nursing noticed a lained the evaluation to use				
		k into consideration the				
		tability, muscle tone, past				
	medical history, and	d limitations of range of				
		ained to his knowledge no				
		essments had been completed				
		had started with the facility. stated awareness of two				
		for R8 which had occurred				
	, , ,	weeks. NA-C stated the first				
		on the evening shift and the				
		ned during the day shift.				
		indicated an awareness R8				
		sode while on the mechanical ot aware of how many times it				
	had occurred.	or aware or now many times it				
	-At 2:06 p.m. during	g an interview with				
		I, and the RDCS, the RDCS				
	stated staff would r	not fill out an incident report for				
		during a sit to stand sfer unless the resident				
	machanical lift tran					

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		AND HUMAN SERVICES				FORM	D: 05/04/201 MAPPROVE D. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245323	B. WING			03	3/27/2018
NAME OF F	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
					209 BIRCHWOOD AVENUE WEST PO	BOX 700	
WALKER	REHABILITATION &	HEALTHCARE CENTER		1	WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 689	documentation wou stated if there was would be involved t resident would be r assist with a sit to s one. RDCS confirm	age 110 ather a recap of the medical uld be performed. RDCS a second episode then therapy to evaluate transfers and the equired to have two staff stand mechanical lift instead of ned the care plan directed staff s with stand by assist versus a	F 6	589			
	pass out while on the her that she had parts stated she had only short time and had instruction on what -At 2:44 p.m. NA-D pass out. NA-D state aware that R8 had was from other nur told her. NA-D furth there were no spect	stated she had not seen R8 he lift rather, R8 had informed assed out on the lift. NA-E y worked at the facility for a not been given any special to do to if R8 "passed out." stated she had not seen R8 ted the only reason she was passed out while on the lift sing assistants and R8 also her stated to her knowledge tial instructions to ensure the lift transfers or what to do					
	-At 2:46 p.m. RN-E passing out while on new interventions. -At 2:47 p.m. RDCS other documentation than on 3/9/18, and lack of documented episode, no further because intervention notification to the p blood pressure me further indicated if the documented episod have been two staff lift. RDCS, acknow	stated an unawareness of R8 on the lift and there were no S confirmed there was no on of syncopal episodes other I indicated since there was a d evidence of more than one interventions were necessary ons of therapy evaluation, hysician and lowering of the dications were effective. RDCS there was more than one de, then for sure R8 would f assist with the mechanical vledged the reason for pably because of low blood					

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PRINTED: 05/04/2018 FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING	i		03/2	27/2018
NAME OF PRO	VIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER R	EHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
pr nu re th m de co -A sa no re st: liff re ho in fo we v re pa we Ol ha ar pa tw -A tra LF be -A as st: ar tra fo st fo fo st fo fo fo fo fo fo fo fo fo fo fo fo fo	ursing did not agree commendations to ought the sit to sta aintain her dignity ecision. However, ompleted. At 3:24 p.m. PT-A afe transfers on 2/ of able to help R8 dated to anxiety or ated R8 was able t, however, PT on equired to complete the lift. PT-A furth r the appropriate se ere needed to com- control to complete the lift. PT-A furth r the appropriate se ere needed to com- control to complete the lift. At 7:40 ad not received transister of stated the staff erson unless the re- to staff were used at 7:45 a.m. LPN-E aining on the med PN-B stated all med e performed with the sessed R8 after to ated she had notified then got an ord ecause if she let g	kness. RDCS indicated be with the PT o use the full body lift and and lift was better for R8 to and mobility based on a team an assessment was not verified he evaluated R8 for 9/18. PT-A indicated he was stand and perhaps it was to ther behavioral issues. PTA to stand with the mechanical ly evaluated for the type of lift e a safe transfer and not know ce a resident would need once her stated PT did not evaluate sling size or how many staff inplete a transfer safely and o determine that based on the full medical history, f resident, and resident's a.m. RN-D confirmed she aining on the mechanical lifts used mechanical lifts with one esident was combative, then 3 verified she had not received hanical lifts since hire date. echanical lift transfers should	F	589			

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUU		ONSTRUCTION		<u>). 0938-039</u> TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					MPLETED	
		245323	B. WING			03	8/27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 WAI	OX 700	DX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 689	• • • • • • • • • • • • • • • • • • • •	-	F 6	89				
	dangerous for her to use. RN-B stated therapy recommended a full body lift for R8, but did not know why R8 continued to use the sit to stand lift -At 2:38 p.m. NA-F stated an awareness of the							
	-At 2:38 p.m. NA-F stated an awareness of the syncopal episodes because R8 had passed out on her four to five weeks ago, near the end of February, and she also witnessed another							
	episode prior to 3/9 passed out on a nig	also whilessed another /18. NA-F further stated, R8 ght person, and another day indicated she thought there						
	was another episod the 3/9/18, episode	de which had happened after NA-F stated she reported all nurse, but the NAs did not						
	if anything was doo done about it. NA-F to the attention of c time was not aware	sing notes so we did not know cumented or if anything got indicated she had brought it one of the nurses, who at that e of the episodes and then the						
	•	dications were adjusted. a.m. NA-G described the						
	assisting R8 to tra going to faint and the limp, she grabbed When help arrived	de on 3/9/18. She was nsfer and R8 stated she was hen "passed out." R8 went her waist and called for help. they placed R8 in a chair. R8 til once in the chair. NA-G						
	added she did not R8 alone.	feel comfortable transferring						
	was removed on 3/	pardy that began on 3/9/17, /27/18, at 12:00 p.m. after the d a removal plan which						
	assessment for R8	e plan to direct the care staff						

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		AND HUMAN SERVICES			FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245323	B. WING		03/	27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	stand or body me warranted. - Discussed risks at power of attorney of to stand sift. - Developed and im procedure regarding residents while in a - Staff were educate standing lift policy at R18's Admission Re diagnosis of mild co transient ischemic at and hemiparesis, at movements, and eg epilepticus. R18's quarterly MD had severe cognitive extensive assist fro mobility and toilet u 2+ staff members for R18's current care indicated R18 requisist staff for dressing, b mobility, and two st R18 with a full body right sided hemiples care plan also ident disorder and and hi failed to indicated w the staff were to us the lift. On 3/20/18, at 1:11	chanical lift when conditions nd benefits with R8 and R8's f the continued use of the sit plemented a policy and g the safe handling of	F 689			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 114	F 6	89			
	room and informed her into bed. NA-B footrests, connecter mechanical lift, and transfer R18 into he members were press R18's Lift Mobility S 12/20/17, indicated pounds and could to position. The tool in for a full body lift. H a comprehensive as included which lift to use, and how many to safely transfer R The tool indicated:	R18 she was going to transfer removed the wheelchair d the lift sling to the proceeded to independently er bed. No other staff sent at the time of the transfer. Status evaluation tool dated R18 weighed less than 500 olerate a semi-reclined ndicated R18 was a candidate owever, the evaluation lacked ssessment/evaluation which o use, which lift sheet/sling to v staff members were required 18 using the mechanical lift. "This is only a guide and	FO	89			
	conditions. Only a to and therapy or qual will create the safes staff, while meeting and improving patie	circumstances and medical eam approach with nursing lified personnel involvement st situation for the patient and the goal of increasing mobility ent health." a.m. NA-B stated one staff					
	person could transf body lift and had all one staff person. Na feel comfortable us person could help. I performing a transfe	ier the residents using the full ways transferred R18 with only A-B stated if the NAs did not ing the lift alone, another NA-B also stated at the time of er with a mechanical lift the additional help was needed.					
		C stated she had not ever og on the use of mechanical					
		a.m. RN-D stated she had not the mechanical lifts since hire					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ·	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		MPLETED
		245323	B. WING			3/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484	OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COI		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 689	date. RN-D indicate with one person un combative, then tw -At 7:45 a.m. LPN- received training or lifts since hire date transfers should be The Superior Healt Region Mechanica 12/23/17, did not a requirements prior and did not direct s comprehensive ass lift type, sling, and transfers. The polic procedure was to h device to safely ass staff to review the r for any special nee also indicated two r required to perform transfers, and one sit to stand mechanica use as: Sara 3000 working load of 440 on a horizontal surf hospitals, nursing h facilities where the assessed to corres categories: was ab least one leg, had s	ed staff used mechanical lifts less the resident was o staff were used. B also stated she had not n how to use the mechanical and that all mechanical lift e performed with two staff. hcare Management Minnesota Lifting Devices policy effective ddress staff training to the use of mechanical lifts, taff to perform individualized sessments for the appropriate number of staff to ensure safe ey indicated the purpose of this nelp lift residents using a lifting sist with transfers and directed resident's care plan to assess ds of the resident. The policy nursing assistants were n full body mechanical lift nursing assist could perform a	F 6	89		

Facility ID: 00995

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D/	<u>O. 0938-039</u> ATE SURVEY OMPLETED
ND FLAN C	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG		
		245323	B. WING		•	3/27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WALKER, MN 56484	WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 689	Continued From pa staff and residents	-	F 6	89		
	fully understand the operators needed t accessories, function -Before using the line assessment of the stability be perform and an individualized medically qualified	ft it was mandatory to read and e instructions. In addition, the o be trained on the lift's ons and controls. ft a comprehensive resident's condition and ed by a qualified staff member ed resident assessment by person must be performed as lower leg straps were required.				
	instructions for use to be used under p where the patient h themselves, canno able to bear weight passive, might be a bedridden, is often totally dependent o The lift instructions staff and residents -Before using the lift fully understand the	and warnings to avoid injury to				
	accessories, function -The need for a second resident must be as resident by a medica a one or two personant appropriate based condition, behavior staff members. -The manual further the resident's hand					

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	i	COM	IPLETED
		245323	B. WING	-		03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	200	
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	injuries and/or dam Smoking: R13 routinely indep and the facility failer comprehensive smo R13's safety while s On 3/20/18, at 12:3 wheeling from dinin was going outside t -At 6:27 p.m. R13 w wheelchair, waiting the dining room are to smoke. -A 6:32 p.m. R13 w hat on. Obtained his are stored at the nu He applied the smo and lap and procee dining room door w and smoked his cig followed by disposin receptacle. On 3/21/18, at 2:01 outside on the back dressed appropriate apron was draped a smoked without diff cigarette in the app	 age to the Maxi Move. bendently smoked cigarettes d to complete a oking assessment to ensure smoking. b) p.m. R13 was observed ag room area and stated he to smoke soon. c) p.m. R13 was observed in his for all the residents to leave as o he could go out the door c) as observed with his coat and s cigarettes and lighter which urse's station, from the nurse. c) wheel himself out the thich lead to the patio. R13 lit parette without difficulty and of it in the appropriate c) p.m. R13 was observed the roors chest area and lap. He ficulty and distinguished the ropriate receptacle. c) p.m. R13 was observed 	F 6				
	apron was draped o	<pre>< patio, smoking. A smoking over his chest and lap area. smoking or distinguishing the</pre>					

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 118	F6	689			
		p.m. RN-E stated if a nt was not documented then it					
	comprehensive sm completed as she of the previous therap smoking assessme longer provide serv	p.m. RN-A confirmed a oking assessment was not could not find one. RN-A stated y company completed the ents, however, since they no ices at the facility, she is onsible to complete them.					
	DON stated a comp assessment should	8 a.m. the administrator and prehensive smoking I have been completed any significant change in the					
F 690 SS=D	Center Smoking Ru Grandfathered Res residents who were must have a smokin nursing, and must v smoking materials i station. Bowel/Bladder Inco	er Rehabilitation & Healthcare ules and Regulations for idents form indicated grandfathered in to smoke, ng assessment completed by wear a smoking apron. All must be kept at the nursing untinence, Catheter, UTI 1)-(3)	F	690			5/6/18
	resident who is con admission receives maintain continence	facility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical mes such that continence is					

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING	i		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•	
WALKER	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX VALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	Continued From pa	-	F	690			
	incontinence, based comprehensive ass ensure that- (i) A resident who e indwelling catheter resident's clinical co catheterization was (ii) A resident who indwelling catheter is assessed for rem as possible unless demonstrates that o and (iii) A resident who receives appropriat	sessment, the facility must nters the facility without an is not catheterized unless the ondition demonstrates that					
	ensure that a reside receives appropriat restore as much no possible. This REQUIREMEN by: Based on observat review, the facility f comprehensive bla	a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel the treatment and services to ormal bowel function as NT is not met as evidenced tion, interview and document ailed to complete a dder assessment to determine			This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, subm	or the hission	
	1 of 2 residents (R catheter. Findings include:	for an indwelling catheter for 5) who utilized an indwelling			of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law.	or that of and	
		num Data Set (MDS) dated R5 had moderate cognitive			1. It is the policy of the facility to bowel/bladder incontinence care of		

Facility ID: 00995

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	S FOR WEDICARE	& MEDICAID SERVICES				<u>NB NO.</u>	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			· /	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
IAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO E WALKER, MN 56484			00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 690	Continued From pa	ge 120	F6	690			
	impairment and dia disease, quadripleg indicated R5 require members for bed m activities of daily livi R5 utilized an indwe R5's admission MD as dependent upon living and utilization R5's Urinary Inconti Catheter Care Area 9/6/17, indicated R5 catheter. The CAA comprehensive ass R5's Bladder Assess indicated R5 had ur unable to be treated surgically. The ass indwelling catheter. was not comprehen the catheter was pla catheter, bladder in function history. R5's care plan date indwelling catheter care for the catheter symptoms of infecti	gnoses included Parkinson's ia and depression. The MDS ed total assistance of two staff hobility, transfers and all ing. The MDS also indicated elling urinary catheter. S dated 9/1/17, identified R5 staff for all activities of daily of the catheter. inence and Indwelling Assessment (CAA) dated 5 utilized an indwelling Foley A did not include a bessment of the catheter. issment Form dated 11/22/17, rinary retention which was d or corrected medically or essment indicated R5 had an However, the assessment asive as it did not identify when aced, attempts to remove the fection history or past bladder d 9/6/17, indicated R5 had an and directed the staff how to ar and to monitor for signs and			 catheter maintenance care to all rebased on appropriate diagnosis and assessment. One of the many ways this has been achieved for resident completing comprehensive assess catheter and updating diagnosis bar use and medical symptoms. After so noted that information was missing regarding catheter immediately the diagnosis was determined, and ord were reviewed. R5 was noted to har urinary retention and had been pressince injury that left him impaired. If an accidental catheter removal noter resident did not have output and was emptying urine – was determined or monitor output overnight. Resident significant output catheter reinserter noted good output. In summary bla unable to empty on own and catheter necessary. Care sheets and care pupdated. 2. Because all residents are requised. So that have catheters are potentially affected by the cited deficiency. DC reviewed with staff appropriate diagmonitoring, risks of infection and replacement of catheters. All current residents assessed for continence bowel and bladder assessments ar appropriate interventions for toileting check and changing have been put 	d s that #5 is ment of sed on survey ers ve sent During ed as not ould had no id and dder er was lans red to use all DN gnosis, nt via nd	
	for 7 days for the tre	d on Macrobid (an antibiotic) eatment of a urinary tract cal record did not contain a is.			 place and catheters have been revi Care sheets updated and care plan other residents were affected. The on catheters has been reviewed. 3. To enhance currently compliant 	. No policy	

Facility ID: 00995

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	IPLETED
		245323	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 690	Continued From pa	ige 121	F 69	0		
	was observed to had on the side of R5's emptied the cathete On 3/21/18, at 1:10 (DON) reviewed R8 had a diagnosis of admission to the fa the catheter. The D treated for a urinary facility, however, the indicate if R5 had b need of the cathete attempted to be rer the facility had not of assessment for the indwelling catheter. A policy related to in requested and non-	p.m. the director of nurses 5's record and indicated R5 urinary retention upon cility and R5 was admitted with DON confirmed R5 had been y tract infection while at the e clinical record did not been evaluated for medical er or if the catheter had been moved. The DON confirmed completed a comprehensive e continued need of the	F 69	director of nurses, on 5/1// received in-service training toileting, incontinent care, change programs, and car The training emphasizes to of following a plan of care diagnosis, catheters and a monitoring. Also educated appropriately assessing to and appropriate interventid 4. Effective 4/17/2018, a quality-assurance program implemented under the su director of nurses to monit with catheters and updatin and care plans with any cl ensure appropriate follow director of nurses or desig quality-assurance represe perform the following syste the DON or designee will a with catheters in conjuncti assessment and intervent weeks to ensure catheters have orders, are changed documented if any infectio control log. Any deficiencie corrected on the spot, and the quality-assurance commit further review or corrective 5. DON will be responsit	g for appropriate check and theter usage. he importance , reviewing appropriate l on bileting needs ons. n was apervision of the tor residents ng MD, family nanges to through. The gnated entative will ematic changes: audit residents on with ions for first eekly for 5 s maintained, and ons in infection es will be d the findings of cks will be ed at the monthly tee meeting for e action.	
SS=D	CFR(s): 483.25(i)					

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			()(0) 1 11 1			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245323	B. WING		03/2	7/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 695	tracheostomy care	and tracheal suctioning.	F 69	5		
	needs respiratory of care and tracheal s care, consistent with practice, the compri- care plan, the reside and 483.65 of this s This REQUIREMED by: Based on observa- review, the facility f positive airway pres- ordered for 1 of 1 m a CPAP machine. I ensure a system w disinfecting oxygen	asure that a resident who care, including tracheostomy suctioning, is provided such th professional standards of rehensive person-centered lents' goals and preferences, subpart. NT is not met as evidenced tion, interview and document ailed to provide a continuous ssure (CPAP) machine as esident (R5) who was to utilize n addition, the facility failed to as in place for changing and/or therapy equipment for 1 of 3 wed for oxygen therapy.		This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, subm of this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state federal law. 1. It is the policy of the facility to respiratory care to all residents ba	or the or that or that of and provide	
	11/24/17, (admission identified R5 as have sleep apnea. R5's was to utilize a CP4 sleep apnea) every R5's quarterly Minin	th Nursing Home Note dated on history and physical) ving a diagnosis of obstructive primary physican indicated R5 AP machine (used to treat r night "indefinitely." mum Data Set (MDS) dated		appropriate diagnosis and assess One of the many ways that this has achieved for R5 is determining ac need for cpap machine and gettin accordingly. R3 has had oxygen n tubing, humidifier container all rep The TAR has been updated to chas all tubing and containers weekly o	ment. as been tual g order nachine laced. ange out n nights	
	impairments and di disease, quadripleg indicated R5 requir members for bed n	R5 had moderate cognitive agnoses included Parkinson's gia and depression. The MDS ed total assistance of two staff nobility, transfers and all ing. The MDS did not indicate machine.		 and labeled accordingly. After surnoted that faulty system for o2 that immediately addressed and the cyreviewed with MD. Care sheets ar plans updated. Because all residents are required have proper access and assistance respiratory equipment all are pote 	at was bap was and care uired to be with	

Facility ID: 00995

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	DMB NO.	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245323	B. WING		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 695	Continued From pa	ge 123	F 695	5		
	machine.	0		reviewed treatment sheets to ens	ure staff	
				updated on when to change out a		
		d 9/29/17, did not address the		monitor equipment. All current res		
	use of a CPAP.			assessed for dated tubing, proper containers clean and full for prope		
	On 3/20/18, at 1:45	p.m. R5 was assisted to bed		humidity. No other residents were		
	by nursing assistan	ts (NA)-B and NA-F. A CPAP		affected. The policy on oxygen ha		
		bserved in R5's room, nor		reviewed.	4	
	apply.	rved to locate a machine to		3. To enhance currently complia operations and under the direction		
	appi).			DON, on 5/1/2018 all staff will rec		
		as assisted to bed for the		in-service training for appropriate		
		NA-D. After completing cares, bserved to assist R5 with a		use and monitoring of the system Residents with cpap machines ha		
	CPAP machine.			reviewed to ensure equipment av and documented. The training		
	On 3/21/18, at 1:00) p.m. the regional director of		emphasizes the importance of fol	lowing a	
		DCS) reviewed R5's clinical		plan of care, reviewing diagnosis,	and	
		confirmed R5 had an order to hine each night as directed,		appropriate monitoring. 4. Effective 4/17/2018, a		
		addressed on the care plan		quality-assurance program was		
	and a machine had			implemented under the supervisio	on of the	
				DON to monitor residents with cp	•	
		p.m. registered nurse (RN)-E cal record and confirmed R5		and oxygen. The DON or designation quality-assurance representative		
		CPAP machine, however, no		perform the following systematic		
		regarding the CPAP was in the		the DON or designee will audit all	Ū	
		RN-E could not recall R5 ever		residents for 3 weeks than 1 resid		
	utilizing a CPAP ma	achine.		weeks to ensure oxygen tanks an equipment properly dated and hu		
	On 3/23/18, at 10:0	0 a.m. family member (FM)-A		sanitized and clean. Any deficience		
	stated R5 had receipt	ived a CPAP machine prior to		be corrected on the spot, and the	findings	
		left him as a quadriplegic.		of the quality-assurance checks w		
		5 was not comfortable with the I did not like it. FM-A stated the		documented and submitted at the quality-assurance committee mee		
		ver questioned use of the		further review or corrective action		
		l it had not been utilized since		5. DON will be responsible for the	is POC.	
	R5 was admitted to					

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245323	B. WING	i		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	SHOULD BE C	
F 695	The CPAP/BiPAP S directed the staff to directed by the phy the device, staff wa R3's Treatment adr March 2018, reveal liters of oxygen as a start date of 10/28/ when the oxygen tu how the oxygen hu maintained. R3's care plan lack maintence of oxyge On 03/19/18, 9:29 a nasal cannula was concentrator; the tu contained condens bottle connected to dated. R3 stated s night, had her own humidifier bottle, a last time the tubing sometimes the tubi it wasn't supposed On 3/20/18, at 12:3 and the oxygen tubi contained condens On 3/21/18, at 9:20 and oxygen tubing tubing contained cod	Support policy dated 12/17, supply CPAP assistance as sician. If the resident refused s to notify the physician. ministration record (TAR) for ed a physician's order for 2 needed for dyspnea with a 18. The TAR did not reflect bing should be replaced or midifier bottle should be ed identification of care and en equipment. a.m. R3's oxygen tubing with observed on the oxygen ubing was not dated and ation bubbles. The humidifier the concentrator also was not he used oxygen mainly at sterile water to use in the nd was not aware of when the had been changed. R3 stated ing ends up on the floor where to be. 5 p.m. R3's humidifier bottle ing was not dated. The tubing	F	695			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	-At 8:20 a.m. register oxygen tubing was changed weekly an were indicated on the tubing was not date determine when the -At 8:53 a.m. licens stated oxygen tubin date they were last tubing was suppose LPN-B verified the I and the amount of of LPN-B then replace aware if the humidit or disinfected. On 3/26/18, at 10:2 stated the oxygen tu it was last changed Undated facility polit General Infection C of disposable equip 7)Thoroughly clean to appropriate stora procedural system	ge 125 ondensation bubbles. ered nurse (RN)-B indicated supposed to be dated and d thought the tubing changes ne TAR. RN-B stated if the ed, there would not be a way to be tubing was last changed. ed practical nurse (LPN)-B ing should be marked with a changed and thought the ed to be changed weekly. ack of the date on the tubing condensation in the tubing. ed the tubing. LPN-B was not fier bottle was to be replaced 7 a.m. the administrator ubing should be dated of when and would provide a policy.	F 6	95			
F 725 SS=F	requested and not r Sufficient Nursing S	Staff	F 7	25			5/6/18
		nt Staff. ve sufficient nursing staff with npetencies and skills sets to					

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		AND HUMAN SERVICES			F	TED: 05/04/20 ORM APPROVE NO: 0938-039		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			3) DATE SURVEY COMPLETED		
		245323	B. WING	G		03/27/2018		
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
F 725	resident safety and practicable physical well-being of each of resident assessme and considering the diagnoses of the fa accordance with the at §483.35(a)(1) The by sufficient number types of personnel nursing care to all of resident care plans (i) Except when wa this section, license (ii) Other nursing per limited to nurse aid §483.35(a)(2) Except paragraph (e) of the designate a license nurse on each tour This REQUIREMENT by: Based on observation review, the facility for staffing was available assistance with inco- of motion services, turning and reposition residents' assessed care plan. This lack	d related services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care e number, acuity and cility's resident population in e facility assessment required facility must provide services ers of each of the following on a 24-hour basis to provide esidents in accordance with : ived under paragraph (e) of ed nurses; and ersonnel, including but not es. ept when waived under s section, the facility must ed nurse to serve as a charge	F	725	This Plan of Correction constitutes m written allegation of compliance for the deficiencies cited. However, submissi of this Plan of Correction is not an admission that a deficiency exists or t one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ens sufficient nursing staff to provide basic care needs to residents based on the residents □ plan of care. It was	é ion hat d sure c		

Facility ID: 00995

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLI			0938-039 SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					LETED	
		245323	B. WING			03/2	7/2018	
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
VALKEF	REHABILITATION &	HEALTHCARE CENTER		09 BIRCHWOOD AVENUE WEST PO BOX 700 /ALKER, MN 56484	3OX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 725	Continued From pa	ge 127	F 72	25				
	Based on observati review, the facility fa assistance with incor residents (R2, R23) on staff for incontin- provide grooming a residents (R23) who shave. See F677. Based on observati review, the facility fa repositioning as dire 4 residents ((R5, R had a pressure ulce development of pre Based on observati review, the facility fa motion services as decline on range of residents (R5, R2) of services. The failuro resulted in actual ha sustained a decline See 688. Residents: On 3/19/18, at 10:5 orientated resident services, stated shap periods of time (mo assistance. R3 state could not always wa her to get onto the b once assisted onto	 90 127 on, interview and document ailed to provide timely ontinence cares for 2 of 2 who were totally dependent ence cares and failed to ssistance for 1 of 2 male o required staff assistance to on, interview and document ailed to provide timely ected by the care plan for 4 of 818, R2, R23) who currently ers or were at risk for the assure ulcers. See F686. on, interview and document ailed to provide range of directed in order to prevent a motion abilities for 2 of 5 observed for range of motions e to provide the services arm for R5 and R2 who had in range of motion abilities. 9 a.m. R3 an alert and who received hospice e had to sometimes wait long ore than 10 minutes) for staff ed she took a diuretic so she ait for staff assistance to help bedside commode. R3 stated the commode, she would just transfer herself back off 		20	determined from survey team that residents did not get the cares they needed for activities of daily living as evidenced by R2 and R23 did not hav timely assistance with incontinent care who required total dependence, R 23 not have grooming assistance with shaving and was dependent on staff t provide; R5, R18, R2 and R23 did not have timely repositioning as directed I the plan of care and are at risk for the impaired skin integrity. R2 and R5 did have range of motion provided as directed I the plan of care and are at risk for the impaired skin integrity. R2 and R5 did have range of motion provided as directed I by therapy recommendations. R3, R FM B and R 18 all expressed concern with providing necessary services due not having sufficient staff to meet resi needs. NA-C, NA-A, RN-A, NA-B, LP RN-B expressed ongoing concerns w staffing that affected their ability to complete expected duties. Nurses identified management aware of concern and had put in place mandating policy few staff hours have changed to cover meal times which was an area many set felt lacked adequate coverage as expressed by NA□s. Since survey, 2 NAR□s have been brought in through contract, recruitment has been high priority, increased wages put in place, distributed within 30 miles and corporate recruiter posted on all active recruitment sites. The facility determit that no admissions will be accepted u all present staff are current on training requirements, deemed competent in skills, and until appropriate staffing is	res did to t by e d not ected 21, ns e to ident 2N-B, <i>i</i> th cerns y, a er staff n re ined until g		

Facility ID: 00995

DEPARTMENT OF HEAL CENTERS FOR MEDICA						FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO	PPLIER/CLIA	. ,			(X3) DATE	E SURVEY PLETED
	2453	323	B. WING			03/2	27/2018
NAME OF PROVIDER OR SUPPLI	ĒR			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				20	9 BIRCHWOOD AVENUE WEST PO BOX 7	00	
	a HEALINCARE C			W	ALKER, MN 56484		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIE NCY MUST BE PRECEDE R LSC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
 there were only evening shifts ar walk by without of were running arc periods were in it meals, and at be when she had to was only one aid about the safety emergency situated and questioned two emergencies. At 9:14 a.m. R2: stated the facility members to protithere were only nurse on most whe/she had turne for assistance, hit time for the staff busy. At 10:45 a.m. fa his/her loved on receiving assistance situated situates in the staff busy. At 11:48 a.m. R2 was enough staft to wait longer for shift. R18 further 	b long waiting for h wo aides on during of the nurses seem offering to help whil ound. R3 stated the he morning, before dtime, but stated n wait the longest be e. R3 stated she w for other residents tion like a fall, beca d consume the avai what would happen	a the day and hed to just le the NAs e longest wait e and after hight shift was ecause there vas concerned in case of an ause the hilable staff if there were hted resident, gh staff . R21 stated nts and a R21 knew if on to summon to wait a long they are so B stated s without shaving re why her sistance and enough staff or t think there emed to have overnight t always	F 7	25	deficient practice of insufficient staf which ultimately affects timely assis with incontinent cares, range of mo services being provided and timely assistance with turning and repositi Regarding staffing; shifts were char add increased support during need times, two-way radios initiated to in communication for assistance need between CNAs and nursing departr agency staffing assistance contacts additional support. SSC initiated a recruitment campaign to increase marketing areas for recruiting poter new hires, as well as reaching out t staffing agency support until vacant positions have been filled, reached potential candidates through social to inform of openings, sign on and to bonuses and have reached out inter to other facilities for additional hand support for CNA, LPN, and RN management support which has be provided to facility. 3. To enhance current recruitment efforts and overall operations and u the direction of the DON and ED, o 5/1/2018 all staff will discuss incent and bonuses to help facility reach of employment candidates. The trainin emphasize the importance of all sta addressing resident needs, includir importance of response to call light assistance with ADLs and expectat licensed staff and non-licensed staff residents as needed. 4. Effective 4/18/2018, a quality-assurance program was implemented under the supervision	atance tion oning. nged to ed crease led ment, ed for staff ntial o to ut to media referral referral referral referral refunder n ives but to ng will aff s, ions of ff to aid	

Facility ID: 00995

			(V2) MUU TU			0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED		
		245323	B. WING			27/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC				
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	D BOX 700	3OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 725	Continued From pa	age 129	F 72	5				
	 Staff: On 3/19/18, at 12:40 p.m. nursing assistant (NA)-C stated the facility had 23 residents and only two NA's to provide direct care during the day and evening shifts. The night shift only had one NA. NA-A stated the NA's were able to just get the residents' basic cares done. NA-C also stated the NAs were responsible to provide range of motions exercises with morning cares, however, this was not being provided because there was not enough time to. On 3/22/18, at 6:34 a.m. registered nurse (RN)-A stated didn't feel like there was enough nursing assistants to take care of the residents. RN-A stated management was aware of the concerns and had put a mandating policy into place and temporary staff was contracted for a few weeks which seemed to help, and then a couple of staff 			 continue supporting current staff during this restructuring to appropriately care for the residents. 5. The DON and ED along with corporate recruitment team will be responsible for the POC. 				
	had been hired. Sta scheduling was bas of the residents. RI have three aides du shifts and one aide and that seemed a indicated concerns situations during th around and the leve when only one nurs short handed, staff RN-A further indica challenging becaus available to help fer assistance. On 3/22/18, at 7:15	ated staff was told staff sed on census and not acuity N-A stated the facility used to uring the day and on evening on during the overnight shift, lot more sufficient. RN-A pertaining to emergent e night shift with only two staff el of acuity, stated often times se was scheduled or worked were not able to take breaks. ted meal times were se there wasn't enough staff ed the residents who required 5 a.m. NA-B stated the NAs did omplete documentation of						

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STATEMENT	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	ING		MPLETED		
		245323	B. WING		03	8/27/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST F WALKER, MN 56484	O BOX 700	OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		SHOULD BE	(X5) COMPLETIO DATE		
F 725	Continued From pa resident cares beca	ige 130 ause they were too busy	F 7	25				
	providing cares. N toileting and reposi residents, however those care tasks tin stated the NAs did	A-B stated the NAs provided tioning assistance to the , they were unable to complete nely, as directed. NA-B also not have time to provide range as with morning cares because						
- s a n t L e s a w c n n L c r	stated the NAs wer answering call light not have the time to two hour cares as o LPN-B stated "they enough time in the stated when a NA o assigned day shift, work as a NA which complete all the nu meal times were th number of staff req LPN-B stated the s could and confirme	sed practical nurse (LPN)-B e busy all day long. Between s and providing cares, they did o provide assistance with every directed by the care plans. can not do it, there is not day to get it done." LPN-B did not show up for their one of the wing nurses would n left only one nurse to rsing duties. LPN-B stated the e most difficult because of the uired to assist the residents. taff did the very best they d the residents' did not always exercises, shaving or oral of staff.						
	staffing at the facilit time, the facility has RN-B stated 10 of t required mechanica body) to transfer ar assistance of at lea In the past, the faci NAs during the day staff were able to ti	0 a.m. RN-B stated the ty was a challenge. At this d many dependent residents. the 23 current residents al lifts (either standing or full nd 18 of the 23 required list one staff to complete cares. lity had two nurses and three and evening shifts and the mely assist the residents with ls and exercises. RN-B stated						

Facility ID: 00995

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED		
		245323	B. WING			007/0040		
	PROVIDER OR SUPPLIER	240020		STREET ADDRESS, CITY, STATE, ZIP CODE		8/27/2018		
		HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484		X 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 725	reduced, however, three to two aids, the taken into consider On 3/24/18, at 8:40 was the worst she f was very frustrated resident ratio. -At 10:00 a.m LPN- facility had utilized agency who provide facility, however, the the facility several work not replaced them. members were tire On 3/27/18, at 8:34 director of nursing facility staffing. The hired on 1/17/18, at administrator that he staff recruitment ar stated immediately the ineffective disse and was currently if and implementation the staff members administrator stated appointed on 2/5/18 staff recruitment ar administrator acknown nursing assistant hevening shifts and new scheduled pos- positions were filled to help the nursing	when it was reduced from ne resident care acuity was not ation. a.m. NA-B stated the staffing had seen in many years and with the current staff to B stated in the past, the a supplemental nursing ed pool staff to work in the e pool staff had quit working at weeks ago, and the facility had LPN-B stated the staff	F 72	25				

Facility ID: 00995

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	OF DEFICIENCIES	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED	
		245323	B. WING		03	/27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0		
WALKEF	R REHABILITATION &			209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETIO DATE		
F 725	Continued From pa	age 132	F 72	5			
		ice from the corporate office to er, her request was not					
	improvement (QAF a prioritization plan The plan identified needed based on or staffing goal as: -three nursing assi staff with a ward as one to two aides or census and acuity one 8 hour LPN, an hour LPN for day/e for the facility inclu- at local hospitals for running advertisem on 1/15/18, for two	Assurance and performance PI) log dated 1/16/17, identified for increasing staffing needs. what staffing levels were census and acuity with the stants for morning shift, two ssistant on the evening shifts, in the overnight (depending on of residents), one 12 hour RN, and one 12 hour RN and one 8 evening shifts. The staffing plan ded social services marketing or appropriate residents, ments for staff, signed contract temporary nursing assistants, sistance from the corporate					
	indicated the avera residents. The ass services the facility diseases/condition identified the acuity identifying them by and resource utiliza and percentages. identified number of needed was betwe hours for licensed number of direct ca The assessment a	ment last revised 3/19/18, age daily census of 20-25 essment indicated care and could provide included s and cognitive disabilities and of the current residents by level of assistance required ation group (RUG) categories The facility assessment of nursing assistant hours en 48-72 hours per day and 32 staff per day with a total are hours per day as 80-104. Iso included the nursing home eport which indicated nursing					

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						FORM	APPROVED
		IDENTIFICATION NUMBER:					
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER				00	
	SUMMARY STA			-	-	N	(¥5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION)	IAG		DEFICIENCY)	RIATE	DAIL
	245323 B. WING						
F 725	Continued From pa	ge 133	F 72	25			
	state and national a	averages.			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
		su the following.					
	hours per resident	per day).					
	From 2/17/18-2/28/	18, average daily resident					
	evening shifts (2.17	nursing assistant direct care					
	hours per resident of	day).					
	From 3/1/18-3/19/1	8. average daily resident					
	hours per resident of	day).					
	Superior Healthcard	a Management Minnesota					
	Our facility provides	adaquata staffing to most					
	population.						
		· · · · · · · · · · · · · · · · · · ·					
		ains adequate staffing on that our resident's needs and					

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED	
		245323	B. WING _		03/	27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	DX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 725	and licensed nursir and monitor the de	age 134 icensed registered nursing ng staff are available to provide livery of resident care services assistants are available on	F 72	5			
F 726	each shift to provid services of each re resident's compreh 6. Staffing will be b facility needs.	e the needed care and sident as outlined on the ensive care plan. ased on resident census and	F 70	6		E/6/19	
	Competent Nursing CFR(s): 483.35(a)(3)(4)(c)	F 72	6		5/6/18	
	the appropriate cor provide nursing and resident safety and practicable physica well-being of each resident assessme and considering the diagnoses of the fa	ervices ave sufficient nursing staff with npetencies and skills sets to d related services to assure attain or maintain the highest attain or maintain the					
	licensed nurses ha and skill sets neces needs, as identified	facility must ensure that ve the specific competencies ssary to care for residents' I through resident described in the plan of care.					
	limited to assessing	iding care includes but is not g, evaluating, planning and ent care plans and responding					
		ncy of nurse aides. Isure that nurse aides are able					

If continuation sheet Page 135 of 250

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		E SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	СОМ	PLETED	
		245323	B. WING		03/2	27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 726	Continued From pa	ge 135	F 72	6			
		npetency in skills and					
		ary to care for residents'					
	needs, as identified assessments, and	described in the plan of care.					
	This REQUIREME	NT is not met as evidenced					
	by: Record on obconvet	lion intonvious and de aurora - 4		This Dian of Correction constitute	0.001/		
		tion, interview and document ailed to ensure staff were		This Plan of Correction constitute written allegation of compliance for			
	trained and deeme			deficiencies cited. However, subr			
		ential abuse and the		of this Plan of Correction is not ar			
		eporting requirements for 3 of 3		admission that a deficiency exists			
		sidents with actual and streatment incidences;		one was cited correctly. This Plan Correction is submitted to meet	1 01		
		oping and implementing		requirements established by state	and		
		needs for 1 of 1 resident		federal law.			
		charged without a plan dge of cardiac pacemaker care		 It is the policy of the facility to that there are sufficient nursing st 			
		sident (R6) who had a		the appropriate competencies and			
	pacemaker without	staff knowledge of monitoring		sets to provide nursing and relate			
		of the identification of and		services to assure resident safety			
		comprehensive assessment pring and documentation		highest practicable physical, men psychosocial well-being of each re			
	5 5	essure ulcers in order to		Since survey findings, all staff have			
	prevent the worsen	ing of a pressure related		educated and are competent in			
		idents (R5, R18) who had		identification of potential abuse ar			
		e ulcers which had worsened; and were knowledgeable on		investigation and reporting require for all residents resulting in finding			
		I resident lifts to ensure safe		R226, R13 and R5. Education an			
		or 2 of 2 residents (R2, R8)		knowledge for use of mechanical	lifts was		
		afety concerns during the use		immediately provided to all staff to			
		and failed to ensure staff were he identification of infectious		safe transfers for R2, R8. System place for identification of infectiou			
		/when to implement infection		outbreaks and how to implement			
	control precautions	in order to prevent the spread		control precautions to prevent spr	ead of		
		failures also had the potential		infections. R6⊡s pacemaker che			
	to affect all 23 resid	lents residing in the facility.		been clearly identified and DON a facility educated on proper identifi			
	Findings include:			and complete assessments, mon			
	~			and documentation for pressure u			

Facility ID: 00995

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		AND HUMAN SERVICES			I	FORMA	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (>	,	SURVEY
		245323	B. WING			03/2	7/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From pa	ae 136	F 7	26			
	Abuse reporting: F6	-		20	prevent the worsening of pressure ul for all residents after findings on R5 a		
	resident abuse, elo origin and the staff as potential abuse and immediate repo and/or State agenc R13 stated during in	- nterview on 3/19/18, at 9:24			R18. Resident R24 no longer resides facility to correct appropriate discharge planning needs however discharge planning process has been develope any current residents discharging. O 3/26/18 it was determined by DON at ED that competency training lacked documentation to support how staff v	s at ge ed for On nd were	
	currently lived a cou he could not get ald would threaten to "H being just two days months ago, when with staff present, F	to be his roommate and uple doors from him, however, ong with R21. R13 stated R21 beat him up" most recently ago. R13 stated about two he was by the nursing station R21 had "rolled up and			effectively trained. It was determined training needed to be completed on a employees to address proper orienta to policies and procedures as well as annual requirements. In addition, licensed nurses and nursing assistant have additional requirements specific	all ation s nce c to	
	being injured. R13 s witnessed the incid down." R13 denied "all he is, is one big stay away from R22 interviews confirme	left shoulder." R13 denied stated the staff who had ent told R21 he had to "settle being afraid of R21 and stated mouth" and that he tried to 1 as much as he could. Staff ed the incident had occurred clinical record lacked			their title and were determined to need proper competency testing of all area determined based on resident popula their job title, and areas identified three survey, staff, residents, families and quality assurance committee. The far determined that no admissions will be accepted until all present staff are cu	as as ation, ough the acility e	
	interventions implei safety, and lack of r and State agency.	ne incident, investigation and mented to ensure R13's reporting to the adminstrator om the facility according to the			on training requirements, deemed competent in skills, and until appropr staffing is in place. DON and design immediately began proper competen trainings for all staff and new staff will orientated through proper orientation	iee icy II be	
	facility's computeriz list. The note indicative within the facility so search was conduct locating R226 and 9 called, they informer resident was at the	a building and grounds a building and grounds a building and grounds and which was unsuccessful in 911 was called. When 911 was ad the facility their missing local police department. The resident to the facility,			 All residents can be affected by incompetent nursing staff. All employ files and training records were review from Relias Learning, current orienta for new hires after 2/8/2018 and othe individualized education provided sin survey. The DON along with HR and 	ved ation er ace	

		& MEDICAID SERVICES	(X2) MU	TIDI		IO. 0938-039 DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				OMPLETED
		245323	B. WING			3/27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 726	Continued From pa	ge 137	F 7	26		
	unharmed. The fac facility Minnesota Ir Management List w 7:30 a.m. and revis R226 had eloped fr temporary wanderg 15 minute checks w lacked evidence the However, further st elopement whereas wheeled self down crossed the main h station. The intervie been returned to th person. R226's clin evidence of this elo was investigated or R5's Progress Note indicated R5 had a bruise which was y pinkness surroundi documentation did was located on R5. Set (MDS) dated 1/ cognitive impairment activities of daily liv A Resident Bruise/S 3/13/18, indicated F bruise on the right f caused by an arm f and director of nurs	ility provided a copy of their noident Report from the Risk which was dated 12/3/17, at ed on 12/5/17, which indicated rom the facility and a guard was placed, and every vere initiated. However, it e Stage agency was notified. aff interview revealed another is R226 had exited the building, the snow covered road, and ighway and was at a gas ews also revealed R226 had e facility by an unidentified ical record lacked any opement having had occurred, reported. e dated 3/13/18, at 11:20 p.m. 6.0 centimeter (cm) by 3.0 cm vellow/green in color with some		20	determined a series of trainings, in-services, 1:1 trainings, return demonstrations, Relias Learning and packets for review for all staff based on their individualized training requirements 3. Upon review and completion of all competencies, re-orientation and annual training requirements, the DON will complete a 1:1 performance evaluation with each nursing employee to ensure competent staff, and review what other training and education needs should als be included for quality assurance purposes. All new hires will have completion of orientation and training consistent with facility policy. All casual employees unable to complete necessa training will not be allowed to work at facility until after completion and 1:1 review with DON. 4. Beginning 4/24/18 the DON, mentor DON and RN will provide all RNs with above educational training and will reviee monitor and assist staff to ensure completion. Ongoing monthly in-service will be provided and tracked by DON (or designee) to assure continued compliance. Education programs will identify areas of weakness determined from performance reviews, resident nee and areas identified in the monthly QAP reviews. All nursing staff's individual competencies will be completed by 5-6- 2018, as well as being current on compliance training. All new hires will have completed competencies during orientation. Monthly for 6 months the	l o ry w, es ds
		p.m. when requested to buse prevention policy and			facility will continue to monitor that assigned annual and deemed appropria	te

Facility ID: 00995

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· /	E SURVEY PLETED
		245323	B. WING			0.2/	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	03/4	2772010
		HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	{	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 726		-	F 72				
 procedures, the administrator and director of nursing (DON) stated they were unable to local it within the facility. -At 1:49 p.m. the administrator and the DON confirmed R13's and R21's dislike for each oth The administrator, the DON and the regional director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred an confirmed it should have been reported to the administrator as well as the State agency, as required. 		ted they were unable to locate dministrator and the DON nd R21's dislike for each other. the DON and the regional services (RDCS) were ercation and all stated they altercation had occurred and d have been reported to the			trainings are completed monthly. A deficiencies will be immediately con and findings will be documented ar reviewed at the monthly quality ass committee meeting. 5. The DON will be responsible for POC.	rected, nd urance	
	RDCS, and the DC from the facility and When asked about program related to the whole system r administrator state started at the facilit failure in the system the staff on the abu policies and proceed situation, they were elopement and sta	5 p.m. the administrator, DN confirmed R225 had eloped d the incident was not reported. t the facility's abuse prevention reporting, the RDCS stated needed to be "revamped." The d when her and the DON ty, they became aware of the m and had begun educating use prevention program dures. When notified of the IJ e informed of R226's additional ted they were unaware of this nfirmed it too should have required.					
	On 3/21/18, at 8:40 had only been with company for three time at the facility. the Superior Health executive who ove executive stated th of the facility on 2/2	D a.m. the RDCS stated she the facility's management weeks and this was her first At this time, the RDCS called hcare Management (SHM) rseen this facility. The le company took over operation 1/17, whereas there was a who continued to work at the					

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION		· ·	E SURVEY PLETED
		245323	B. WING			03/27/2	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CI			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AV WALKER, MN 564	VENUE WEST PO BOX 70 184	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD E RENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From pa	ige 139	F 7	26			
	which ended June 3 started working at t for overseeing the o November 2017. Fo departure, there was assigned to this "pr supervisor was not available for consul RDCS verified and facility systems and binder to place the program policy and staff education. On 3/26/18, at 3:26 (LPN)-A stated she facility abuse preve "Tuesday" (six days was kept at the nur facility's policy and prohibition in which needed. However, if any changes had	ownership transition phase 2017, at which time a RDCS he facility and was responsible clinical nursing operation until ollowing this employee's as no specific regional director operty" therefore a clinical present on site, rather was ltation via the phone. The acknowledged the lack of a stated she would create a facility abuse prevention procedures in and provide 6 p.m. licensed practical nurse was shown the newly created ontion program binder last s prior) and verified the binder ses station and contained the procedures related to abuse staff were to refer to when LPN-A stated she did not know been made to the facility's ause she had not reviewed the					
	Discharge Planning	j: F660					
	to identify the need discharge plan prio	d to home and the staff failed to develop and implement a r to R24 leaving the facility in 4's safe and successful ome.					
	diagnoses that incluing a contract of the second se	to the facility on 12/15/17, with uded but were not limited to: a procedure, cerebrospinal eneralized muscle weakness,					

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	TIPLE CONSTRUCTION	OMB NC (X3) DA	TE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	l`´´	NG		MPLETED		
		245323	B. WING		03	/27/2018		
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE				
WALKEF	R REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE		
F 726	and headache. Rev summary dated 12, underwent a dural i a lumbar fusion wit was given IV antibi- home to receive IV was admitted with a central catheter) lin Review of R24's dis progress note date going to discharge driving herself in he indicated R24 want to a Walgreens clos note also identified with her primary ca health care and foll discharge planning which indicated R2 personal car at 10: brace and was able	view of the hospital dismissal /14/17, indicated R24 repair for a CSF leak following h a resulting infection. R24 otics and sent to the nursing antibiotics until 12/21/17. R24 a PICC (peripherally inserted	F 7:	26				
	indication if R24 wa and doff the back b PICC, if R24 could dressing on the low dressing supplies to Additionally, there we signs and symptom the primary care pr indication R24 rece medications were, on those medication need for home care referral to a home I completed and if R admission. The do	as able to independently don vrace, who would care for the independently change the ver spine or if R24 had o change the dressing. was no evidence of teaching of as of infection or when to call ovider. There was no vived medications, what those and if R24 had been educated ns. Although R24 indicated a e, there was no indication a nealth agency had been 24 was accepted for cument Discharge Summary e Plan of Care dated 12/22/17,						

Facility ID: 00995

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STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED		
		245323	B. WING _		03	/27/2018		
NAME OF	PROVIDER OR SUPPLIER		l	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	21/2010		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE		
F 726	was incomplete. The wanted home healt and the names of the telephone numbers was no indication if On 3/23/18, at 11:0 (DON) stated the far discharging resider teaching should have indicated if R24 was back brace, if R24 change the dressing had discharge medic the PICC line should care should have be and a referral to a light have been initiated signs and symptom been reviewed, and physician phone nu provided. The DON a discharge policy of have included train planning at the time provided a new dis dated 12/23/17. Cardiac pacemake R6 had a cardiac p to acknowledge the the pacemaker to e R6's quarterly MDS with moderate cogn	closed record. The summary be summary indicated R24 th agency recommendations wo agencies and their swere listed. However, there the agencies were contacted. 44 a.m. the director of nursing acility did not have a system for nts. The DON stated patient ve been documented and s able to don and doff the was able to independently g on the lower spine, if she lications and what they were, Id have been pulled or home been set-up to ensure it's care, nome health agency should and set-up. Additionally, the ns of infection should have d the surgeon and primary care umbers should have been A stated the facility did not have and procedure which would ing of staff on discharge e of R24's discharge. the DON charge policy and procedure r care: F684 acemaker and the staff failed e need for routine monitoring of ensure proper functioning.	F 72					

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	E SURVEY PLETED
		245323	B. WING	i		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	required limited ass activities of daily liv Summary dated 6/1 complete a pacema using a remote hon care plan dated 6/2 pacemaker due to a the staff to monitor altered cardiac outp such as dizziness, s pulse rate lower that than baseline blood plan did not direct t pacemaker via tele R6's clinical record to the pacemaker n On 3/22/18, at 1:05 (LPN)-B confirmed stated the schedule to be completed by stated the schedule on the electronic M Records (EMAR). and stated the EMA to complete pacem LPN-B entered the a pacemaker telept confirmed she had utilized the machine nurse (RN)-E review stated the clinical re as to the last time t checked and she w concern.	sistance of one staff for all ing. R6's Hospital Discharge 19/17, indicated R6 was to aker check over the telephone ne monitor on 7/18/17. R6's 28/17, identified R6 had a atrial fibrillation and directed for signs and symptoms of out or pacemaker malfunction syncope, difficult breathing, an programmed rate or lower I pressures. However, the care he staff to assist to monitor the phonic monitoring.	F	726			

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		AND HUMAN SERVICES			FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245323	B. WING		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 726	Continued From pa the pacemaker eva On 3/27/18, at 9:30 completed R6's pac telephone in Februa not documented the record. RN-D state monitoring, an addi been made. RN-D received any type o pacemaker clinic wi concerns with the p would expect the cl there was a probler awareness of the ne monitoring/schedule of follow up in order was functioning pro Pressure Ulcers: F6 R5 and R18 were in development of pre observed to have cl worsened and the li the change and/or of assessment of the ul efficacy of the treatu interventions were i harm to R5 and R8	ge 143 luations. a.m. RN-D stated she had cemaker check via the ary 2018, however, she had e monitoring in the medical ed at the time of the tional appointment had not stated the facility had not if documentation from the hich would indicate any bacemaker. RN-D stated she inic to contact the facility if n. RN-D did not voice eed to ensure routine ed checks or the importance r to ensure R6's pacemaker operly. 386 dentified at risk for the ssure related ulcers and was urrent ulcers which had icensed staff failed to identify complete a comprehensive ulcer and implement routine cers in order to determine ment, and ensure implemented which resulted in num Data Set (MDS) dated	F 726	DEFICIENCY)		
	1/10/18, indicated F impairment and dia disease, quadripleg indicated R5 require members for bed m	R5 had moderate cognitive gnoses included Parkinson's jia and depression. The MDS ed total assistance of two staff nobility, transfers and all ing. The MDS also identified				

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		& MEDICAID SERVICES				MB NO.	APPROVEI 0938-039	
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		PLE CONSTRUCTION		E SURVEY PLETED	
		245323	B. WING			03/2	27/2018	
NAME OF	PROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEP	R REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	(700		
(X4) ID PREFIX TAG				х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 726	Continued From pa	age 144	F 7	' 26	6			
	R5 at risk for the de	evelopment of pressure ulcers.						
	(CAA) dated 9/6/17 development of pre dependence upon bowel incontinence staff to complete w monitor R5's skin v cares. R5's care pl	er Care Area Assessment 7, identified R5 at risk for the essure ulcers due to staff for repositioning and e. The assessment directed reekly skin assessments and to vhile assisting with personal an dated 8/28/17, directed the rith repositioning at least every						
	staff to apply a Der to the coccyx every addition, R5's Orde order for the same directed the staff to	der dated 11/29/17, directed mFilm Thick Sacral Dressing / three days, and as needed. In er Summary also included an wound dated 10/3/17, which o apply an Allevyn Dressing the left buttock wound and to e days until healed.						
	reviewed and revea and sacral pressure R5's clinical record of the wound/s whi measurements of t depth), color of the	/18, through 3/20/18, were aled R5 had buttock, coccyx e ulcers which had worsened. lacked a weekly assessment ch would include he wound, (length, width and wound and surrounding rrent interventions. R5's clinical						
	physician had beer areas. In addition, Administration Rec revealed duplicative DermFilm dressing	evidence that R5's primary notified of the newly opened R5's Electronic Treatment ord (ETAR), dated 3/18, e orders to apply Allevyn and s every three days to the same documentation revealed the						
	DermFilm dressing wound areas. The nurses had initialed							

Facility ID: 00995

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STATEMENT	OF DEFICIENCIES OF CORRECTION	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245323	B. WING		03	/27/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		/21/2010	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 726	applied to the wour dressing was actual On 3/20/18, at 5:00 in a wheelchair in the for supper. -At 5:05 p.m. registe evening meal. -At 5:20 p.m. RN-D turned the televisio -At 5:55 p.m. R5 re Nursing assistant (I assisted R5 to was change into a hosp repositioned. -At 6:06 p.m. NA-D in the chair and cor -At 7:50 p.m. NA-D room and transferre bed. R5's wheelchate redistribution seat of was covered with a hydrocolloid dressin the wound was dee - At 7:55 p.m. NA-A bed at 4:00 p.m. an repositioned for 3 h stated with only two doing the best they unable to provide at repositioning for all On 3/21/19, at 1:10 confirmed R5 was for pon stated she was	ad, even though only one illy applied. P.m. R5 was observed seated he main dining room waiting ered nurse (RN)-D fed R5 the wheeled R5 back to his room, n on and exited the room. mained in his wheelchair. NA)-D entered R5's room and h his hands and face and ital gown. R5 was not exited the room. R5 remained ntinued to watch television. and NA-A returned to the ed R5 from the wheelchair to air had a pressure cushion in place. R5's coccyx in intact thin Tegaderm ng. The skin along the edge of ep pink in color. A stated R5 was assisted out of nd confirmed R5 was not pours and 50 minutes. NA-A p NAs on staff, the staff were could, however, they were assistance with timely		26			

Facility ID: 00995

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245323	B. WING _			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	Continued From par documentation, she size of the pressure facility should have skin assessment wi - At 2:05 p.m. RN-E Duoderm dressing removal of the dress newly opened areas measured the first of to be 1.0 cm x 0.3 of the lower left buttoo cm. In addition, un- three deep red app blanchable areas. changed appearance observed it. RN-D new and the wound - At 2:10 p.m. the D The DON stated the R5's sacrum, the ski intact. The DON co developed stage 2 p partial thickness ski dermis, or both). R dressing over the u	age 146 e was unable to determine the e ulcer. The RDCS stated the completed a comprehensive hen the breakdown began. D was observed to remove a from R5's sacrum. Upon asing, RN-D identified two s under the dressing. RN-D open area on the left buttocks cm. The second open area on cks measured 2.0 cm by 2.0 der the dressing there were roximately one inch non RN-D stated the wound had ce since the last time she had stated the open areas were looked worse. DON observed R5's sacrum. e last time she had observed kin was dry and flaky but onfirmed R5 had newly ulcers (pressure ulcer in which in loss involving epidermis, 2N-D applied a Duoderm	F 72	26			
	days later) revealed related to the newly wound care and me	d a lack of documentation developed pressure ulcer's easurements from 3/21/18.					
	pressure ulcer and any type of docume assessment related	ed R5 had developed a the facility failed to complete entation or comprehensive d to the new pressure ulcers 8. RN-E verified R5 had two					

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MEILTI	PLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
		245323	B. WING		03	8/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
WALKE	R REHABILITATION &	HEALTHCARE CENTER		BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 726	treatment orders fo the ETAR indicated applied even thoug applied to the wour care plan had not b R5 had not receive with the facility polid R18's Admission R R18 had diagnoses impairment, stroke, muscle weakness, and obesity. R18's indicated R18 had required extensive mobility and toilet u on 2+ staff for trans- indicated at the tim- stage 2 pressure ul ulcers (Stage 3- Fu Subcutaneous fat n tendon or muscle a be present but does tissue loss. May ind tunneling) which mu Ulcer treatments in and pressure reduce wheelchair. R18's care plan prin- required extensive bathing, grooming a extensive assist of mechanical lift. The "has pressure ulcer pressure ulcer area	r the same sacral wound and l both dressings were being h only one dressing had been nd. RN-E also verified R5's been followed as directed and d wound care in accordance	F 72	6		

Facility ID: 00995

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 70 WALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	to implement the fo facility policies for the skin breakdown, mail every shift to ensure adhering, to monito any changes in skir color, wound healin infection wound size every two hours or the perform weekly skir identified, treatment measurement of ear width, length, depth (drainage). Although the care pulcers, the care plat developed pressure to reflect the pressure to reflect the pressure 3/2/18, MDS assess R18's physician ord skin assessment or -wound evaluation of Monday per MD ord -Change Tegaderm moist wound bed) the days in the morning prep to coccyx befor prevent skin tears. 3/20/18) -Monitor Tegaderm upper buttocks even is in place, dressing Dressing to remain 9/30/17) -Comfort foam (for with border dressing	llowing interventions: follow he prevention/treatment of onitor dressing, if needed, e if remains intact and r/document/report, as needed, n status such as appearance, g, signs and symptoms of e, and stage, reposition R18 more often, if needed and to n observation. If open area t documentation to include ach area of skin breakdown's a, type of tissue exudate plan addressed pressure n did not address the newly e ulcers and/or was not revised ure ulcers identified on the	F7	726			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING _			03/:	27/2018
NAME OF I	PROVIDER OR SUPPLIER	•	<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKEF	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7 ALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	-Roho cushion for v Weekly Skin Review from 1/1/18, throug pressure ulcers, ho comprehensive eval documentation in o worsening, and or h evidence of pressure On 3/19/18, at 11:4 her room, seated in she had pressure u for a long time, and she sat too long. R ⁻ wheelchair cushion R18 further stated s her timely and felt th reposition her more On 3/20/17, at 1:17 transfer R18 from h full body mechanica wounds on her bott bottom since 3/16/1 told her R18 had ac breakdown. NA-B p exposed two hydroo over the left buttock and the mid right bu on the left was new -At 1:39 p.m. medic unit coordinator (HU MD-B asked R18 if from the sores, to w some discomfort. A dressings, MD-B re	wheelchair (start date 3/20/18) ws (WSR) and PNs reviewed h 3/20/18, revealed worsening ovever lacked completed aluations and consistent rder to ascertain locations, nealing stages and lacked re relieving device efficacy. 8 a.m. R18 was observed in the wheelchair. R18 stated licers on her bottom, had them 8 experienced discomfort when 18 stated she did not think her had been changed/replaced. staff did not always reposition hey could probably offer to e often. 7 p.m. NA-B was observed to ner wheelchair into bed using a al lift. NA-B confirmed R18 had toom but had not seen R18's 18, and stated somebody had dditional areas of skin pulled down R18's pants, which colloid dressings positioned k and sacral/coccyx region, uttock. NA-B stated the wound	F 72	26			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 70 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	the wound descripti efficacies. -At 8:48 a.m. RN-D designated RN to p assessments, there whichever nurse wa RN-D stated skin as weekly, wound doct include measureme pressure ulcer the r stage of the ulcer. F assessing nurse ne causal factors of the implement appropri stated if the pressur the interventions sh effectiveness and th and surfaces should effectiveness. -At 12:49 p.m. RN-F Observations were comprehensive. RN should have been of measurements inclu- then staged, a com drainage, odor, curr toward healing, and reassessment of int new interventions, a RN-E stated the fac-	ds and verified/documented ion, treatment and intervention stated there was no verform pressure ulcer/wound efore were completed by as assigned to work that day. ssessments were performed umentation should always ents, and if the wound was a nurse should indicate the RN-D further stated the veded to determine possible e breakdown and evaluate and iate interventions. RN-D re wounds were not healing, nould be reassessed for he pressure relieving devices d also be assessed for Scomplete nor N-E stated all the evaluations completed to identify: uding depth, if pressure ulcer plete description of the wound, rent treatment, progress d if worsening then terventions, implementation of and notification to physician. cility nurses were very eir documentation and it was a exactly what was going on	F 7	726			
1							

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STATE NUMBER OF DEFICENCIES (X1) PROVIDERSUPPLET (X2) DATE SUPPLET (X2) DATE SUPPLET MALE OF PROVIDER OR SUPPLET 24523 B: WING			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WALKER REHABILITATION & HEALTHCARE CENTER 299 BIRCHWOOD AVENUE WEST PE OBCX 700 WALKER, MN 56434 MULTER, MN 56434 PROVIDERS CITY, STATE, ZIP CODE F 726 Continued From page 151 R Z and RB required staff assistance with transferring via a mechanical full body or sit to stand the adult facility falled to ensure staff were trained and deemed competent on its use. R Z's annual MDS dated 11/2/17, indicated R2 did not have the ability to blear weight on his/her legs. R2 had the ability to blear weight on his/her legs. R2 had the ability to blear weight on his/her legs. R2 had the ability to blear weight on his/her legs. R2 had the ability to blear weight on his/her legs. R2 had the ability to blear keight of aff mumber of statist NA-C as R2 had not been assessed to identify th	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY
WALKER REHABILITATION & HEALTHCARE CENTER 29 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, NN 5643 (X4) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REQUESTIONY OR LSC DENTFYING INFORMATION) ID PREFX TAG IC CONSECTION (EACH DORREST PLAN OF CORRECTION DEFICIENCY) 000000000000000000000000000000000000			245323	B. WING			03/2	27/2018
WALKER REHABILITATION & HEALTHCARE CENTER WALKER, NN 56484 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST RE PRECEDED BY PULL RESULATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH DEFICIENCY MUST RE PRECEDED BY PULL RESULATORY OR LSC DENTIFYING INFORMATION) PROVIDER'S ACH CORRECTIVE ACTION (EACH DEFICIENCY) Comparison (CASS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Comparison (CASS-REFERENCE DEFICIENCY) Comparison (CASS-REFERENCENCE DEFICIENCY) Comparison (CASS-	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
Preferx TAG (EACH OPERCENCE AULTS BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 726 Continued From page 151 R2 and R8 required staff assistance with transferring via a mechanical full body or sit to stand lift and the facility failed to ensure staff were trained and deemed competent on its use. F 726 R2's annual MDS dated 11/2/17, indicated R2 had severe cognitive impairment and diagnoses which included Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive staff assistance for all activities of daily living and required total assistance of two staff for all transfers. R2's Lift Mobility Status form dated 12/31/17, indicated R2 did not have the ability to bear weight on his/her legs. R2 had the ability to tolerate a semi-reclined position and indicated R2 was to be transferred with a MaxiMove (brand name of a full body int chanical lift). NA-C positioned a full body iff. RN-C was present in the form was incomplete, as it was blank. R2 had not been assessed to identify the appropriate size aling or the number of staff members required to asfety transfer R2 with the mechanical lift. On 3/21/18, at 12:00 p.m. R2 was observed resting in bed. NA-C positioned R2 from a reclined to a seated position, R2: feet repeatedly bumped the hydraulic support beam. NA-C di ot as R2 was lifted off of the bed via the full body lift. Sing under R2 and position in the sing. When the lift sing was in a seated position, R2: feet repeatedly bumped the hydraulic support beam. NA-C di ot not as RRN-C for assistance in order to protect R2's legs from hitting the support beam as she proceeded to continue with the transfer. When NA-C had R2	WALKER	REHABILITATION &	HEALTHCARE CENTER				00	
R2 and R8 required staff assistance with transferring via a mechanical full body or sit to stand lift and the facility failed to ensure staff were trained and deemed competent on its use. R2's annual MDS dated 11/2/17, indicated R2 had severe cognitive impairment and diagnoses which included Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive staff assistance for all activities of daily living and required total assistance of two staff for all transfers. R2's Lift Mobility Status form dated 12/31/17, indicated R2 did not have the ability to bear weight on his/her legs. R2 had the ability to bear weight on his/her legs. R2 had the ability to tolerate a semi-reclined position and indicated R2 was to be transferred with a MaxiMove (brand name of a full body mechanical lift). The rest of the form was incomplete, as it was blank. R2 had not been assessed to identify the appropriate size sling or the number of staff members required to safety transfer R2 with the mechanical lift. On 3/21/18, at 12:00 p.m. R2 was observed resting in bed. NA-C positioned a full body lift sling under R2 and connected R2 to the full body lift. RN-C was present in the room, however, RN-C did not assist NA-C as R2 was lifted off of the bed via the full body lift. Once in the air, NA-C utilized the lift control pad and positioned R2 from a reclined to a seated position, R2's feet repeatedly bumped the hydraulic support beam. NA-C di not ask RN-C for assistance in order to protect R2's legs from hitting the support beam as she proceeded to continue with the transfer. When NA-C had R2	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
positioned over her wheelchair, RN-C acknowledged R2's feet were repeatedly bumping	F 726	R2 and R8 required transferring via a m stand lift and the fac were trained and de R2's annual MDS d had severe cognitiv which included Park and anxiety. The a required extensive activities of daily live assistance of two st Mobility Status form did not have the abilegs. R2 had the lift R2 from a reclined soling. When the lift R2's feet repeatedly support beam. NA- assistance in order hitting the support beam. NA- assistance in order hitting the support beam. R2 had abile soling. When the trapositioned over her	I staff assistance with echanical full body or sit to cility failed to ensure staff eemed competent on its use. ated 11/2/17, indicated R2 e impairment and diagnoses kinson's disease, dementia ssessment indicated R2 staff assistance for all ing and required total taff for all transfers. R2's Lift dated 12/31/17, indicated R2 lity to bear weight on his/her ility to tolerate a semi-reclined ed R2 was to be transferred rand name of a full body the rest of the form was as blank. R2 had not been the appropriate size sling or members required to safety mechanical lift. 0 p.m. R2 was observed C positioned a full body lift connected R2 to the full body ent in the room, however, NA-C as R2 was lifted off of body lift. Once in the air, t control pad and positioned to a seated position in the sling was in a seated position, t but by the hydraulic C did not ask RN-C for to protect R2's legs from beam as she proceeded to ansfer. When NA-C had R2 wheelchair, RN-C	F7	726			

Facility ID: 00995

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		D. 0938-039 ATE SURVEY
ND PLAN (OF CORRECTION	DENTIFICATION NUMBER:	. ,	NG		MPLETED
		245323	B. WING		. 03	3/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		
WALKER	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE V WALKER, MN 56484	WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIO DATE
F 726	Continued From pa	age 152	F 72	26		
		and assisted by holding R2's bar as NA-C lowered R2 into				
	her room, seated in the room and proce- transfer R2 from th body mechanical li feet were observed lift. NA-B did not ro	00 a.m. R2 was observed in n a wheelchair. NA-B entered eeded to independently ne chair to the bed via a full ft. During the transfer, R2's d to rub against the hydraulic equest assistance from sist with the transfer and e R2 into bed.				
	residents who requ transfers could be of one or two staff	4 p.m. NA-A stated the uired a mechanical lift for transferred with the assistance depending upon how aff member was in operating				
	R8 had diagnoses thrive, diabetes, es weakness, and not treatment or regim 1/22/18, indicated required extensive member for transfe hygiene, and had in Progress notes (PI R8's leg buckled di was made to physi transfers using a m periods of weaknes Evaluation and Pla indicated R8 was m	ecord dated 3/22/18, indicated which included adult failure to ssential hypertension, muscle n-compliance with medical en. R8's quarterly MDS dated R8 had intact cognition, assistance from one staff ers, dressing, personal mpaired balance. R8's N) dated 1/26/18, indicated uring a transfer and a referral cal therapy to evaluate safe nechanical lift as needed during ss. R8's Physical Therapy in of Treatment dated 2/9/18, eferred for evaluations of safe luation indicated R8 had lower				

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DEPARTMENT OF HEALTH		1			FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í				E SURVEY PLETED
	245323	B. WING			03/2	27/2018
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	00	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
transfers with the u stand lift. However, R8's clini mechanical lift eval appropriate sling si needed to transfer stand mechanical li revision to include to only Lift Mobility Sta 11/18/17, which ind mechanical lift. The guide and cannot a medical conditions. nursing and therap personnel involvem situation of the pati the goal of increasi patient health." R8's dated 3/9/18, had "passed out" w lunch. R8 complain large amount of inc would up updated. vital signs (heart ra saturations) were of episode. R8's Physical Thera Treatment dated 3/ referred related to n out" in the sit to sta recommended the mechanical lift for a	-	F 7	726			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DAT	E SURVEY PLETED
		245323	B. WING	i		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 726	••••••	-	F 7	726			
		echanical lift transfers. ecommendation was never					
	and stated she had obtained the sit to s explained it was he facility and had not R8 directed RN-C h around her and how mechanical lift. Onc R8, and connected to tighten the harne R8 informed RN-C during lift transfers. would go slow and catch up. RN-C pro her wheelchair. The around R8's chest,	2 p.m. R8's call light was on to use the restroom. RN-C stand mechanical lift and r second day on the job at the used a mechanical lift before. now to put the lift harness w to connect it to the ce the harness was around to the lift, R8 instructed RN-C ess, and to use the calf strap. of her history of passing out RN-C informed R8 that she wait for R8's blood pressure to be edded to raise R8 up from a harness became very loose however, RN-C continued with sitioned R8 onto a nearby					
	any training on the R8's transfer had be completed. RN-C s used with one or tw upon the resident. If how tight the harne to stand lift. RN-C's list was not availabl On 3/22/18, at 7:40 had not received tra and stated the staff	C stated she had not received use of the mechanical lift and een the first one she had ever tated mechanical lifts could be to people and was dependent RN-C stated she did not know ss should be when using a sit competency evaluation check le at the time of the survey. a.m. RN-D confirmed she aining on the mechanical lifts used mechanical lifts with one resident was combative, then					
	two staff were used						

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		IDENTIFICATION NONDER.	A. BUILDING			
		245323	B. WING		•	/27/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER	2	BTREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO B NALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 726	training on the use hire date. LPN-B sta transfers should be addition, LPN-B sta of orientation. Oxygen/Respiratory R5 had an order for positive airway pres staff failed to ackno order nor ensure R5 use. R5's Essentia Healt 11/24/17, (admission identified R5 as hav sleep apnea. R5's was to utilize a CPA sleep apnea) every quarterly MDS date moderate cognitive total assistance of t mobility, transfers a The MDS did not in machine. R5's clini of the need to use a assessment related machine. R5's care address the use of Observation on 3/20 nor did the staff offe CPAP machine in F	of the mechanical lifts since ated all mechanical lift performed with two staff. In ted she had received two days / care: F695 the use of a continuous ssure (CPAP) machine and the wledge and implement the 5 had the machine in order to th Nursing Home Note dated in history and physical) ving a diagnosis of obstructive primary physican indicated R5 AP machine (used to treat night "indefinitely." R5's d 1/10/18, indicated R5 had impairments and required wo staff members for bed and all activities of daily living. dicate R5 utilized a CPAP cal record lacked identification and also a comprehensive I to the use of a CPAP plan dated 9/29/17, did not a CPAP.	F 726			

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	Continued From pa	uge 156	F 7	'26			
	on the care plan an provided.	d a machine had not been					
	clinical record and of a CPAP machine, h regarding the CPAF	p.m. RN-E reviewed R5's confirmed R5 had an order for nowever, no further information P was noted in the record. In Id not recall R5 ever utilizing a					
	stated R5 had rece his accident which I FM-A stated R5 wa CPAP machine and staff had never que of the CPAP machine	0 a.m. family member (FM)-A ived a CPAP machine prior to left him as a quadriplegic. is not comfortable with the d did not like it, however the estioned R5's family on the use ne and confirmed his personal een utilized since R5 was lity.					
	Infection control: F8	380					
	facility and the staff implement isolation	uenza had occurred at the f failed to identify the need to n precautions and/or infection prevent the spread of					
	initiated on 1/5/18, i positive for Influenz which is spread thro The form identified (R125, R124, and F for Influenza A betw Eight additional res displaying flu like sy limited to fever, cou	nza-like Illness Line List form indicated R12 had tested za A (highly contagious disease ough air droplets) on 1/5/18. three additional residents R6) who also tested positive veen 1/5/18, and 1/15/18. idents were also identified as ymptoms (including but not ugh, muscle pain, headache or entified dates as indicated					

If continuation sheet Page 157 of 250

		AND HUMAN SERVICES				FORM	APPROVED
		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA					0938-0391
	OF DEFICIENCIES	IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
			/				
		245323	B. WING			03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX	700	
				V	NALKER, MN 56484		
(X4) ID		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
F 700	0 1 1 -						
F 726	• · · · · · · · · · · · · · · · · · · ·	ge 157	F 72	26			
	below:						
	-R21 displayed sym	nptoms on 1/5/18, which					
	included sore throa						
	congestion.						
		nptoms on 1/6/18, which temperature of 101.8, and					
		/7 and 1/8/18, symptoms					
	included non-produ	ctive cough, productive cough					
		and increased chest					
	congestion.	n_{1}					
		ptoms on 1/10/18, which ture of 101.2 degrees along					
		ore throat, cough and sinus					
	congestion.	-					
		ptoms on 1/10/18, which					
	•	ture of 101.1 degrees along ore throat, cough and sinus					
	congestion.	ore throat, cough and sinus					
	0	otoms on 1/15/18, which					
		ture of 100.5 degrees along					
	with, sinus congest						
		otoms on 1/15/18, which re of 100.8 degrees along with					
		chills, and sinus congestion.					
	- R227 displayed sy	mptoms on 1/15/18, which					
		ture of 100.8 degrees along					
	sinus congestion.	head ache, cough, chills, and					
		ptoms on 1/17/18, which					
		hills and sinus congestions.					
	Additional review of	f the infection control logs and					
		ords revealed a lack of					
		aforementioned residents had					
		is initiated at the time of the					
	symptom onset and	d/or as well as the personal protective equipment					
		oves, gowns when caring for					

If continuation sheet Page 158 of 250

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	-			/I APPROVE[). 0938-039 ⁻
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245323	B. WING		03	8/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484	DX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 726	residents with symp contamination from provision of cares. evidence the licens deemed competent infectious outbreak infection control pre- utilization of PPE as initiate. The Superior Healt Region Influenza, F Seasonal (influenza, directed the staff to precautions for all r influenza. During the monitori was working as a fl passing resident m new binder which c the use of mechani policies and proced nurses station and review and sign ind understood its cont this training rather, read and learn the shift, when time allo also instructed to p for the staff that we which she had not staff were tested ye had not had a chan -At 9:20 a.m. NA-B "enlightened" regar	booms in order to prevent cross resident to resident during the The facility also lacked ed staff had been trained and t on the identification of s and when and how to initiate ecautions including the s well as isolation measure to hcare Management Minnesota Prevention and Control of a) policy dated 12/27/17, initiate standard and droplet residents identified with ng visit on 3/25/18, RN-B, who oor nurse, was observed edications out. RN-B stated a ontained staff education on cal lifts and infection control dures was placed and the all staff were instructed to licating they had read and ents. Time was not set up for staff were to independently information during their work owed. RN-B stated she was erform staff competency tests are working today (Sunday) in started, and was not sure if esterday or not because she	F 7	726		

		AND HUMAN SERVICES				FORM	D: 05/04/2018 MAPPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		TE SURVEY MPLETED
		245323	B. WING			03	8/27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CO		
WALKER	R REHABILITATION &	HEALTHCARE CENTER			9 BIRCHWOOD AVENUE WEST PO ALKER, MN 56484	BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 726	others could still be person only. Employee Record I On 3/26/18, at 9:0 records were review manager which rev Registered nurse (RN-D's personnel r Description/Competing 1/29/18, which india position was to mo non-licensed perso modifying the treatu physical need of th established medicat requirements of the the facility. The Du section included bu observing resident facilty policy -consult with the re resident care and t -routinely assess th and adjust care plat- is responsible for a evaluation, and rep sudden changes in progress to the phy -is responsible for a	e transferred with one staff Review: 5 a.m employee personnel wed with the business office realed the following: RN)-D was hired on 1/3/18. record contained a Job stency/Evaluation dated cated the purpose of this nitor the performance of nnel and to also assist in ment regiment to meet the e resident in accordance with al practices and the e policies and procedures of the and Responsibilities at was not limited to the duty of: t skin and documentation per sident's physician in providing reatment, as necessary ne total needs of the resident ns as needed accurate observations, orting of resident symptoms, condition reactions and visician and shift supervisor competent adminsitration of s according the physician	F 7.	26			
	evaluation, and rep sudden changes in progress to the phy -is responsible for care and treatment orders and facility p -implementation, pur restorative nursing	orting of resident symptoms, condition reactions and vsician and shift supervisor competent adminsitration of s according the physician policy and procedure rogress and documention of					

Facility ID: 00995

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	со	MPLETED	
		245323	B. WING _		03	/27/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKE	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 726	-attends mandatory The form also indic with the provision o followed proper pro- isolation, PPE, univ when performing pr exposure to to bloo appropriate lifting d staff safety, and wo trained on how to u included 157 compo- which were all date 1/29/18. The form v and the previous Du areas were reviewed that day. The Certified Nursin Description/Evaluat from indicated the N competent in the fo -report all changes charge nurse -performed all assig established policies -follow established to blood/body fluids -perform restorative as instructed -observe and repor and skin breakdown -provide daily range data as instructed -maintained compe competent in hand range of motion	v in-services. ated RN-D was competent f sterile wound care and cedure for hand washing, ersal precautions, use of PPE rocedures that may involve d or body fluids, utilized evices to ensure resident and ould use only the equipment se. However, the form etency requirement areas d as trained/completed on was signed by the employee ON on 1/29/18, verifying all ed, tested and completed on mg Assistant Job tion annual and probationary NA's were trained and llowing non inclusive areas: in resident condition to the gned tasks in accordance with and procedures polices concerning exposure	F 72				

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	OMB NO. 0938 (X3) DATE SURV COMPLETE	VEY	
		245323	B. WING		00/07/00	40	
	PROVIDER OR SUPPLIER	240020		STREET ADDRESS, CITY, STATE, ZIP CODE	03/27/20	18	
		HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	K 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMP	(X5) PLETIO ATE	
F 726	• • • • • • • • • • • • • • • • • • •	-	F 72	6			
	lifting devices to en -reports accidents to duty -uses PPE when perinvolve exposure to - will use only the er trained to use and or safe manner The form had a tota be reviewed and de NA-C was hired on record contained a Job Description/Co 11/22/17. The form competent on all 17 duties of the NA. N	 and uses appropriate sure resident and staff safety to the manager/supervisor on arforming procedures that may be blood or body fluids equipment you have been operate the equipment in a al of 174 competency areas to eemed competent. 12/10/14, NA-C's personnel Certified Nursing Assistant empentency/Evaluation dated in indicated NA-C was 74 identified aspects of the A-C's competency evaluation ts entirety on 11/22/18, by the 					
	record contained a Job Description/Co dated 11/21/17. The competent on all 17 NA-B's competency its entirety on 11/21 NA-D was hired on record contained a Job Description/Co dated 11/28/17. The competent on all 17 NA-D's competence	9/27/93. NA-B's personnel Certified Nursing Assistant impetency/Evaluation form be form indicated NA-B was 74 identified aspects of duty. y evaluation was completed in 1/17, by the former DON. 11/13/17. NA-D's personnel Certified Nursing Assistant impetency/Evaluation form be form indicated NA-D was 74 identified aspects of duty. y evaluation was completed in 2/17, by the former DON.					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT				U936-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	<u> </u>	(X5)
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(IATE	BATE
			1				
F 726	Continued From pa	ge 162	F 72	26			
		6/8/17. NA-H's personnel					
		Nurse Aide Training Inventory ated 6/10/18, in which a					
		cated NA-H had been					
		eas of employment/duties.					
		aining form had not been					
	revewed by a nurse						
		usiness office manager stated					
		ow the staff competency					
	testing and training	had been completed.					
	- At 9:42 a.m. the a	dministrator stated she had					
		y on 1/18/18 and was unaware					
		N had completed the g. However, verified it was not					
		d test all staff on all aspects of					
	their assigned job ir	n a single day. The					
		true competency testing					
	required the staff to demonstrations of t	heir knowledge. The					
		all staff would require					
	retraining.						
	At 0.58 a.m. the b	usiness office manager stated					
		he facility staff had not					
	received training on	the abuse policy, falls,					
	mechanical lifts or i	nfection control.					
	- At 10:10 a.m. the	DON stated new employees					
		zed training on basic practices					
		b training with a co-worker.					
		e was unaware how had been done in the past,					
		not completed competency					
	training for staff sine	ce assuming the DON role six					
		ON stated she would be					
	working on a trainin	ig program.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245323	B. WING			03/;	27/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	Continued From pa	ige 163	F 72	26			
	any type of training	N-A stated she could not recall on abuse, falls, mechanical atrol in the past year.					
	was hired other nur how to use the med never watched a vid stated she didn't rea used the mechanica asked for help. NA- training. NA-G state of orientation, which	a.m. NA-G stated after she rsing assistants showed her chanical lifts however, she deo or took a test. NA-G ally feel comfortable when she al lifts by herself and usually G stated she would like more ed she had received five days h consisted of working on der to get to know the					
	The Facility assess included:	ment last revised on 3/19/18,					
	annually. The forms skill checklists/com shared T drive as w files, and Relias lea their annual require guidelines and the f which occurred in th their birthday. Train identified. NAs and competency checkl hire along with their	tinely completed upon hire and s such as orientation checklist, petencies can be found on the vell as individual employees arning. Employees train on ements identified by regulatory facility, in a classroom setting he corresponding month of ing took place immediately as licensed staff had skill lists that were reviewed upon r orientation training as well as ly with their DON. Training he of the following:					
	-Communication -Resident rights -Abuse, neglect, ex requirements	ploitation and reporting					

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	 -Infection control -Identification of cha -Required in-service Inservice training m continuing competer must be no less that dementia training a training. Competencies inclu -Person-centered c documentation of tr -Activities of daily: of care, perineal care, using gait belt and n -Infection control: h standard universal of personal protectii MRSA/VRE/CDI pro- cleaning -Medication adminisi- Resident assessmant assessment, pressions in respi- specialized care-dia adminsitration, wour- Caring for resident psychosocial disorce nonpharmacologica 	anges in condition e training for nurse aides. nust be sufficient to ensure the ence of nurse aides, but also an 12 hours per year. Include ind resident abuse prevention uded: are: care planning, reatments and medications dressing, feeding, nail and hair , range of motion, transfers mechanical lift. and hygiene, isolation, precautions including the use ive equipment, ecautions and environmental stration uents and examinations: skin ure injury assessment, ponse to treatment iabetic glucose testing, oxygen ind care/dressings ts with mental and ders, implementing al interventions.	F 7	726			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 05/04/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	<i>I</i> PLETED
		245323	B. WING		03/	/27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	X 700	
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484	X 700	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
			1			
F 726	Continued From pa	ge 165	F 72	6		
		2 p.m., registered nurse				
		y was her second day of had not received training on				
	mechanical lifts sind					
	RN-C's competency the time of survey.	y checklist was not available at				
		a.m. RN-D indicated she had g on the mechanical lifts since				
	indicated she had n	ed practical nurse (LPN)-B lot received training on the ce hire date. LPN-B stated she ays of orientation.				

Facility ID: 00995

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	stated after she was assistants showed I lifts however, she n a test. NA-G stated comfortable when s by herself and usua stated she would lik she had received fiv consisted of workin know the resident's The Facility assess included: Staff training is com- routinely. Forms su- skill checklists/com shared T drive as w files, and Relias lea their annual require guidelines and facil that occurs in the co- birthday. Training ta- identified. CNA's and licensed checklists that are n their orientation trai periodically with the Training topics inclu -Communication -Resident rights -Abuse, neglect, ex requirements -Infection control -Identification of cha	a.m. nursing assistant (NA)-G s hired other nursing her how to use the mechanical ever watched a video or took she didn't really feel she used the mechanical lifts ally asked for help. NA-G the more training. NA-G stated we days of orientation, which g on different shifts to get to routines. ment last revised on 3/19/18, apleted upon hire and annually ch as orientation checklist, petencies can be found on the rell as individual employees irning. Employees train on ments identified by regulatory ity need in a classroom setting presponding month of their akes place immediately as a staff have skill competency reviewed upon hire along with ning as well as reviewed ir director of nursing. aded: ploitation and reporting	F 7	226	DEFICIENCY)		
		e training for nurse aides. ust be sufficient to ensure the					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245323	B. WING		03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO NALKER, MN 56484)X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLET	
F 726	continuing competer must be no less that	ige 167 ence of nurse aides, but also an 12 hours per year. Include ind resident abuse prevention	F 726			
F 730 SS=D	-Activities of daily: of care, perineal care, using gait belt and -Infection control: h standard universal of personal protection MRSA/VRE/CDI pro- cleaning -Medication admini -Resident assessment, press observations in res- specialized care- dadminsitration, wou- -Caring for resident psychosocial disord nonpharmacological Nurse Aide Peform CFR(s): 483.35(d)(eare: care planning, reatments and medications dressing, feeding, nail and hair , range of motion, transfers mechanical lift. and hygiene, isolation, precautions including the use ive equipment, ecautions and environmental stration tents and examinations: skin ure injury assessment, ponse to treatment iabetic glucose testing, oxygen and care/dressings ts with mental and ders, implementing al interventions. Review-12 hr/yr In-Service 7)	F 730		5/6/18	
	The facility must co of every nurse aide months, and must p education based or reviews. In-service requirements of §4	ular in-service education. omplete a performance review at least once every 12 provide regular in-service the outcome of these training must comply with the 83.95(g). NT is not met as evidenced				

Facility ID: 00995

If continuation sheet Page 168 of 250

		AND HUMAN SERVICES	1		OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245323	B. WING		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WES WALKER, MN 56484	T PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 730	• · · · · · · · · · · · · · · · · · · ·	ge 168 ure 12 hours of annual	F 73	written allegation of comp	pliance for the	
inservice traini nursing assista personnel reco Findings includ NA-B was hire record indicate 12 required tra 3/26/18. NA-C was hire record indicate	inservice training w	as completed by 2 of 5 (NA-B, NA-C) whose		deficiencies cited. Howey of this Plan of Correction admission that a deficien one was cited correctly.	ver, submission is not an cy exists or that	
	record indicated sh	9/27/93. NA-B's employee e had completed zero of the		Correction is submitted to requirements established federal law. 1. It is the policy of the t	l by state and facility to ensure	
	3/26/18.	hours from 9/27/16 to		12 hours of annual in-ser training is completed by a assistants. NA-B and NA	all nursing -C were given	
	record indicated sh 12 required training	12/10/14. NA-C's employee e had completed 2.75 of the hours from 12/16/16 to		 the complete in-service retrieved they will have scheduled complete 12-hour training 2018. 2. The facility has deter 	times to gs prior to 5-6-	
		9 a.m. the director of nurses \'s were to received 12 hours ear.		residents have to potentia by this deficient practice adequately trained to pro 3. A tracking log of all a	if staff are not vide safe cares.	
Des indic in-se	Description/Compe indicated all NA's w	ed Nursing Assistant Job tency/Evaluations form rere to complete 23 hours of innually tracked from hire date		training has been created assure annual education have been met for all Nu The DON (or designee) v hours of annual in-service	requirements rsing Assistants. vill provide 12 e education for	
				all nurse aids to include in on performance reviews, and areas identified in Q/ completion will be by 5-6- 4. Beginning 4/24/18 th	resident needs API and -2018.	
				designee) has provided a assigned courses throug for 12 hours of annual in- DON (or designee) will m	all NAs with h Relias Learning service trainings. nonitor and assist	
				staff to ensure completion All new hires will begin co orientation before beginn direct resident cares. In	ompletion in ing to provide	

Facility ID: 00995

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		AND HUMAN SERVICES			FORM	: 05/04/2018 APPROVED . 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /			E SURVEY IPLETED
		245323	B. WING		03/	27/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
WALKE	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Provision of Medica CFR(s): 483.40(d) §483.40(d) The fac medically-related so maintain the highes and psychosocial w This REQUIREMEN by: Based on observat review, the facility f and/or arrangemen provide therapeutic resident (R21) who pending in court. Findings include: R21's admission re diagnoses which in	ally Related Social Service		730	 in-services will be provided and tracked by DON (or designee) to assure ongoing compliance and education as determined by quality assurance committee. Education programs will identify areas of weakness determined from performance reviews, resident needs and areas identified in the monthly QAPI reviews. Audits of NA trainings will continue monthly for 6 months to assure that completion of assigned monthly education is occurring. Any deficiencies will be immediately corrected, and findings will be documented and reviewed at the monthly quality assurance committee meeting. The DON (or designee) will be responsible for the POC. 	

If continuation sheet Page 170 of 250

		& MEDICAID SERVICES				<u>1B NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION (E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 70 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 745	Continued From pa	ige 170	F 74	45			
	type II, major depre- insomnia, and aner R21's annual Minim 12/20/17, indicated impairment, had me having little interest feeling tired or havi trouble falling aslee displayed no inappi Review of R21's da very important for F personal belonging and have a place to keep them safe. The extensive assistant for bed mobility, tra	t heart transplant, diabetes essive disorder, heart failure, mia. num Data Set (MDS) dated R21 had moderate cognitive ood symptoms which included to or pleasure in doing things, ng little energy, and had ep or staying asleep, and ropriate behavior symptoms. illy preferences revealed it was R21 to take care of his s, use a telephone in private, o lock personal belonging to ne MDS indicated R21 required the of more than two persons nsfers, and dressing. R21 did used a wheelchair as a mode			medically related social services to e resident. If additional mental health, financial services or substance abus needed, the facility must ensure to n referrals to or collaborate with outsid resources for the resident. The facil failed to provide arrangement or assistance with legal counsel for R2 well as failed to provide therapeutic conversation for this individual who h pending legal issues in court that we urgent. SSD reviewed with R21 and assisted him with receiving legal cou- has completed a psychosocial assessment to identify any unmet ne and has updated the care plan to ref ongoing therapeutic meetings to ass psychosocial and family issues. 2. All residents can be affected by deficient practice due to the obligation the facility to appure that mediaply is	, se is nake de lity 1, as had ere unsel, eeds, flect sist in this on of	
	stated he was frust through a divorce a retained to represe end of February 20 attorney would no le R21 went on to say had many assets in of a business. R21 any income from th nursing home and partners were takin stated he would cal with the aforementi cell phone but could a phone for him. R2 the staff including the	ed on 3/20/18, at 2:11 p.m. and rated because he was going and the attorney he had nt him had sent a letter at the 18, which indicated his onger be representing him. That he owned a home, and heluding having part ownership stated he had not received be business since living in the was worried the business g his share of the profits. R21 Il attorneys to represent him oned legal matters if he had a d not find anyone to purchase 21 stated he had told many of he current social service well as the previous SSD, he			the facility to ensure that medically resocial services are provided to all residents. SSC will complete a psychosocial assessment on all resiby 5/4/18 and will updated the care preflect any changes made. All polici and procedures were reviewed and updated. 3. To enhance currently compliant operations and under the direction of Administrator, the SSD has received education from a LSW on 4/23/18 in facility to increase support, training a education in current SSC role. On 4/24/18 SSC attended presentation in Pathway Health focusing on recent regulatory changes for social worker post-acute care. Also reviewed job description, and regulatory requirem	idents plan to ies of the d n other and from rs in	

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		& MEDICAID SERVICES	0.00				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				E SURVEY PLETED
		245323	B. WING _			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 745	Continued From pa	ge 171	F 74	15			
	was worried due nor represent him in the scheduled for April R21's medical reco progress notes and 11/1/18 - 3/20/18, a had been assessed and there were no p R21 was having dif pending legal/perso A psychosocial ass completed on 10/18 psychosocial issues R21's care plan (un interventions for R2 and family discord I The social services 3/21/18, at 1:03 p.n was aware R21 was currently did not ha The SSD stated sho divorce case was s assisted R21 with th attorney (a phone, I number to legal aid R21 had not been a had any unmet psy 10/18/17. The SSD developed a care p periodically in order therapeutic conversion	ot having an attorney to e divorce hearing that was 10th, 2018. rd was reviewed including all assessments completed and there was no evidence R21 d for any psychosocial issues, progress notes which indicated ficulty or frustration related to onal matters. essment on R21 was last 8/17, but had not identified any s at that time. adated) was reviewed and 21's psychosocial dysfunction had not been developed. designee was interviewed on n. during which she stated she s going through a divorce and ve a divorce attorney retained. e had not asked R21 when the cheduled, and had not he tools necessary to retain an listing of attorneys in the area, e etc). The SSD confirmed assessed to determine if he chosocial needs since confirmed she had not			of medically-regulated social series support ensuring services are prov- as well as situations that would be required but can be obtained from entities. Policies are procedures we reviewed and updated policies. 4. Effective 4/24/2018, a quality-assurance program was implemented under the supervision SSC that all residents will be review time of admission, quarterly and wi notable change to ensure psychose assessments are being completed thoroughly and completely. All trigg be care planned and communicate staff via care sheets and communic book if new interventions in place. This f has provided verbal education to al nursing staff on what to report reganew psychosocial concerns. This f has been provided for licensed staff CNAs in their respective communic logs to communicate to SSC. A psychosocial assessment will be completed for all residents by 5/4/1 SSC. Following initial assessment will continue to audit 25% of reside population each week for 2 months psychosocial assessments, identify and aiding and/or arrangements fo medically-related social services are ensure that services are provided, as assuring ongoing therapeutic m to effectively assist in all resident psychosocial and medical □ related issues. Re-education and reinforce	ided, outside ere n of the ved at th ocial gers will d to cation SSC ll ording form ff and cation 8 by , SSC nt s on <i>v</i> ing r nd as well eetings s	
	On 3/23/18, at 8:43	a.m. a follow up interview was SSD who stated R21 retained			will happen immediately on any discrepancies noted between progr notes, resident statements, care sh	ress	

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TATEMENT OF DEFICIENCIES	ARE & MEDICAID SERVICES			OMB NO. 093	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SUR COMPLETI	
	245323	B. WING		03/27/20	018
NAME OF PROVIDER OR SUPPL	IER		STREET ADDRESS, CITY, STATE, ZIP	, CODE	
WALKER REHABILITATIO	N & HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	[•] PO BOX 700	
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM TE APPROPRIATE	(X5) IPLETIC DATE
she assisted him pay for the attor stated she had exploitation with estranged. The personal cell ph conference call p.m The SSD making a care p visit with R21 at needed, to prov divorce. On 3/27/18, at a interviewed aga attorney quit him he did not have even a phone to could not sleep what was going representation. time eating and eat. R21 stated because when office, they told assist him. He s to follow up with	a page 172 epresent him in his divorce and m in getting a prepaid VISA card ney's retainer fee. The SSD also discussed the potential of finance his wife with whom he had been SSD stated she got R21 a one and that they were having a with his attorney today at 4:00 stated she was in the process of olan which indicated she would teleast weekly, or more often as ide support during this difficult approximately 9:25 a.m. R21 was in and stated that when his n back in February, and he knew access to another attorney or o call one, he felt frustrated and at night due to worrying about to happen if he did not get R21 also stated he had a hard would have to force himself to he was still having anxiety he last spoke to his attorney's him that they could no longer stated the SSD had not stopped on him on where he was at on this ted he did not know how to get a and was still having great anxiety	o ial n f s v	5 etc. The findings of the quality-assurance checks documented, reviewed an appropriate monitoring at quality-assurance commit further review or corrective 5. ED will be responsible	nd continue the monthly tee meeting for e action.	
could not sleep what was going representation. time eating and eat. R21 stated because when office, they told assist him. He s to follow up with	at night due to worrying about to happen if he did not get R21 also stated he had a hard would have to force himself to he was still having anxiety he last spoke to his attorney's him that they could no longer stated the SSD had not stopped him on where he was at on this ted he did not know how to get a	an '			

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TATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA1	<u>. 0938-039</u> E SURVEY IPLETED	
		245323	B. WING		0.2	3/27/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03	21/2010	
		HEALTHCARE CENTER		X 700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 745 F 756 SS=D	account in order to attorney. In addition not shown R21 how stated she would as account and also lin cell phone for ease with the email addre A policy regarding p services was reque Drug Regimen Rev CFR(s): 483.45(c)(§483.45(c) Drug Re §483.45(c)(1) The of must be reviewed a licensed pharmacis §483.45(c)(2) This of the resident's me §483.45(c)(4) The p irregularities to the facility's medical dir and these reports n (i) Irregularities inc drug that meets the (d) of this section fo (ii) Any irregularities during this review n separate, written re attending physician director and directo minimum, the resid and the irregularity (iii) The attending p	receive information from his n, the SSD confirmed she had v to use the cell phone and ssist him in setting up an email hking the email account to his of access and would follow up ess to his attorneys office. bychosocial assessment and sted but not provided. iew, Report Irregular, Act On 1)(2)(4)(5) egimen Review. drug regimen of each resident at least once a month by a st. review must include a review	F 74			5/6/18	

Facility ID: 00995

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						<u>. 0938-039</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	E SURVEY IPLETED	
		245323	B. WING		03/	/27/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
VALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	O BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 756	Continued From pa	ige 174	F 7	56			
	be no change in the	ken to address it. If there is to e medication, the attending ocument his or her rationale in cal record.					
	maintain policies ar drug regimen revier limited to, time fram the process and ste when he or she ide requires urgent act	facility must develop and nd procedures for the monthly w that include, but are not nes for the different steps in eps the pharmacist must take ntifies an irregularity that ion to protect the resident. NT is not met as evidenced					
	Based on observat review, the facility f recommendation fr for 3 of 6 residents	tion, interview and document ailed to act upon om the consultant pharmacist (R2, R23, R1) who had ndations from the pharmacist.		This Plan of Correction con written allegation of complia deficiencies cited. However, of this Plan of Correction is admission that a deficiency one was cited correctly. Thi Correction is submitted to m	nce for the submission not an exists or that s Plan of		
	R2's annual Minimu 11/2/17, identified F impairments and di disease, dementia indicated R2 requir all activities of daily mood or behavior p	um Data Set (MDS) dated R2 with severe cognitive agnoses including Parkinson's and anxiety. The assessment ed extensive assistance with living and did not display problems. The assessment red daily antipsychotic and dications.		requirements established by federal law. 1. It is the policy of the fac pharmacy consultation along review and follow up with all recommendations for MD re R23 and R1 all had pharma consultations and none of th recommendations had been the medications were prima	v state and ility to provide g with drug pharmacy eview. R2, cy ne followed and rily for		
	Seroquel (antipsych a day, remeron (an bedtime, Prozac (a and Klonopin (moo	ers dated 1/2/18, included notic) 25 milligrams (mg) twice tidepressant) 7.5 mg at ntidepressant) 30 mg daily, d stabilizer) 0.125 mg one rs as needed for agitation and		behaviors which documenta plans failed to show any of t existing. After survey noted concerns immediately DON pharmacy to get a reprint of recommendations for march together on 4/19/2018 to rev recommendations and revie	he behaviors these met with any and met <i>r</i> iew		

Facility ID: 00995

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 175 During observations of personal cares on 3/21/18, at 11:30 a.m. R2 was observed to eccive total assistance with cares from nursin assistant (NA)-C. R2 displayed no behaviors. R2's electronic medication administration reco EMAR) for 1/2018- 3/2018, indicated R2 had eccived the schedule doses of Seroquel and Remeron as ordered. R2 had not utilized the I (Jonopin order. The EMAR also included daily locumentation related to potential side effects intidepressant, antianxiety and antipsychotic nedications. The EMAR did not identify R2's	MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	During observations 3/21/18, at 11:30 a. receive total assista assistant (NA)-C. F R2's electronic med (EMAR) for 1/2018- received the schedu Remeron as ordered Klonopin order. The documentation rela antidepressant, ant medications. The E displayed any type medications. The E behaviors associate Review of R2's Cor Medicaiton Review the pharmacist had remeron, Prozac or for a dose reduction indicated he/she ag recommendations, to allow a dose redu- klonopin PRN and behaviors to guide The physican indica with the recommen	s of personal cares on m. R2 was observed to ance with cares from nursing R2 displayed no behaviors. dication administration record - 3/2018, indicated R2 had ule doses of Seroquel and ed. R2 had not utilized the PRN e EMAR also included daily ted to potential side effects of ianxiety and antipsychotic MAR indicated R2 had not of side effects from the MAR did not identify R2's ed with the medications. nsultant Pharmacist form dated 7/20/17, indicated questioned if a the Seroquel, Klonopin could be considered n. R2's primary physican greed with the pharmacist however, R2's family refused uction. nacist Medication Review form cated the pharmacist had macological interventions to to the administration of the to identify the specific target the use of the medication. ated he/she was in agreement dation and directed the staff to acological interventions and	F 7	756	outcomes or corrections. 2. Because all residents receive t medications from our facility pharm and many medications are overly prescribed and resident's condition change, it has potential to affect all residents. A pharmacy consultant m has been held and pharmacy consi- very open to assisting with any que and facility needs. Recommendation all resident's medications were revi- for all residents and plan in place to ensure all residents have proper for through. All staff dispensing medic should ensure they are given and it utilizing prn for more than 14 days MD to do face visit to determine ne and that behavior meds have proper diagnosis and documentation of behaviors. The policy on pharmacy consultation has been updated alor pharmacy policy book provided at r station. No other residents were aff 3. To enhance currently complian operations and under the direction director of nurses, on 5/1/2018 all r staff will receive in-service training pharmacy expectations, monitoring medications related to 14 day rule, behavioral medications and need for reductions and/or behavioral chartii making sure consultation reports a to MD's for orders and that when o are returned copy given to DON. 4. Effective 4/19/2018, a quality-assurance program was implemented under the supervision	acy s neeting ultant stions ons of iewed b llow sations update cessity er ng with nursing fected. t of the nursing on prn or dose ng, and re sent rders	
	A Consultant Pharn	nacist Medication Review form			director of nurses to monitor reside medications and pharmacy follow u		

Facility ID: 00995

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT				0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	· ·				PLETED
		245323	B. WING			03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 700 ALKER, MN 56484	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE
F 756	Continued From pa	age 176	F 75	56			
	requested the staff pharmacological in administration of the indicated target belt the record. The prin agreement with the A Consultant Pharm dated 2/23/18, indic PRN Klonopin in the if the medication co- primary physican in refused to consider discontinuation of t Review of R2's clin specific types of ind displayed. Nor did to non-pharmacologic the PRN Klonopin v lacked a quantitativ her behaviors in ref On 3/22/18, at 2:50 confirmed the const recommendations to lacked documentation completed. RN-E co- have a comprehen- residents behaviors altering medication R23 utilized a PRN did not receive a 14	terventions utilized prior to the be medication. The pharmacist haviors were not identified in mary physican was in e pharmacist findings. macist Medication Review for cated R2 had not utilized the e past month and questioned buld be discontinued. R2's ndicated R2's family member r a dose reduction or he medication. ical record did not identify what dividualized behaviors R2 the record include any cal interventions to attempt if was to be used. R2's record //e and qualitative evaluation of lationship to the medications. 0 p.m. registered nurse (RN)-E sultant pharmacist had made for R2, however, the facility ion that they had been confirmed the facility did not sive system to monitor s in relationship to their mood s. antianxiety medication and 4 day re-evaluation of the			DON or designee will follow up on all pharmacy consultant recommendation immediately, meet with pharmacy consultant monthly to review all medication recommendation started 4/18/2018 then complete 4 audits pe week x 4 weeks, then 2 audits weekt months to ensure compliance with for up on consultation requests. Any deficiencies will be corrected on the and the findings of the quality-assura checks will be documented and subr at the monthly quality-assurance committee meeting for further review corrective action. Pharmacy and DON will be responsi for this POC.	ons ly x2 bllow spot, ance mitted v or	
	antidepressant me	lition, R23 received an dication without adequate continued use of the					

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	<u> </u>				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245323	B. WING			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Continued From pa	ige 177	F 7	'56			
	with severe cognitive including dementia, (inability to speak). required extensive daily living. R23 disphysical aggressive The MDS indicated medications daily a medication 6 of a 7 R23's annual MDS R23 displayed daily aggressive behavior indicated R23 utilized	AS dated 3/9/18, identified R23 ve impairments and diagnoses , history of stroke and aphasia The MDS indicated R2 assistance with all activity of splayed daily verbal and e behaviors towards others. d R23 utilized antidepressant ind utilized antianxiety day review period. dated 10/13/17, also indicated verbal and physical prs towards others. The MDS ed antidepressant medications intianxiety medication 6 of a 7					
	Assessment (CAA) utilized antidepress medications daily.	Drug Use Care Area dated 10/19/17, indicated R23 ant and antianxiety The CAA indicated R23's elf and staff members at risk					
	included an order for (mg) to be given dat and insomnia. The 3/31/17. R23 had a (antianxiety medicat administered as ne- morning and evenir	hary Report dated 2/23/18, or Trazodone 50 milligrams aily at beditme for anxiousness order had been received on a second order for Ativan ation) 0.5 mg to be reded for agitation prior to ng cares with one additional as received on 9/7/17.					
	a history of being pl	ted 3/27/17, indicated R23 had hysically aggressive due to directed the staff to administer					

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PRINTED: 05/04/2018

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245323	B. WING			107/0040	
NAME OF	PROVIDER OR SUPPLIER	240020	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	03	/27/2018	
		HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 756	medication as orde side effects and eff R23's clinical recor behaviors for the u medication. Nor w interventions identi the medication adm Review of R23's ele administration recor received 32 dose of in 2/18, and 23 dos 3/22/18. Review of R23's m of non- pharmacolo prior to the use of t R23's Consultant F form dated 1/20/18 pharmacist had ide antianxiety medicar a PRN antianxiety face to face evalua If the medication w required clinical do need. R23's primary physi indicated R23 had the occasional dos On 3/20/18, at 5:15 warned registered assisting R23 with	er and monitor/document the fectiveness of the medication. In did not identify specific target se of the PRN antianxiety ere non-pharmacological fied to be administered prior to ninistration. ectronic medication ord (EMAR) indicated R23 had of PRN Ativan in 1/18, 48 doses ses in 3/18 from 3/1/18 - edical record lacked indication ogical interventions attempted he PRN medication. Pharmacist Medication Review 6, indicated the consultant entified R23's frequent use of tion. The pharmacist indicated medication required a 14 day tion by the ordering physican. as to be continued, the record cumentation for the continued sician replied on 1/26/18, and significant anxiety and required	F 75				

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>´</i>		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245323	B. WING			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 756		-	F 7	56			
		iate diagnosis, without ng, and there was no r continued use.					
	with severe cognitive including Alzheimer pressure, and type indicated R1 require all activity of daily line symptoms of psych verbal and physical others. The MDS in	6 dated 12/27/17, identified R1 ve impairments and diagnoses r's disease, high blood II diabetes. The MDS ed extensive assistance with ving. R1 displayed no signs or nosis or delirium and had no I aggressive behaviors towards indicated R1 utilized antidepressant medications					
	Assessment (CAA) utilized antipsychoti medications daily w risperdone, and tra	Drug Use Care Area dated 11/3/17, indicated R1 ic and antidepressant which included the medications zodone. The CAA had not ny inappropriate behaviors.					
	R1's Order Summa not provided.	ary Report was requested but					
	for March 2018 indi antipsychotic medic day and 1 mg twice behavioral disturbat exact date could no or through interview Depakote Sprinkles restlessness and ag antidepressant Traz	dication administration record icated R1 received the cation risperdone 0.5 mg every e a day for dementia without nce since May of 2017 (the ot be found in documentation with staff) and received s 125 MG since 1/16/2018 for gitation. R1 received the zodone 25 milligrams (mg) to by for dementia with behavioral W28/17.					

DEPARTMENT OF HEALTH AND HUM/ CENTERS FOR MEDICARE & MEDICA				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE	ER/SUPPLIER/CLIA CATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245323	B. WING		03/2	27/2018
NAME OF PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABILITATION & HEALTHCA	RE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID SUMMARY STATEMENT OF DI PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
 F 756 Continued From page 180 R1's care plan dated last revise indicated R1 target behaviors in wandering, being uncooperativ pacing. The care plan directed administer medication as order monitor/document the side effectiveness of the medication changes to the physician, and pharmacological interventions activity, redirecting, and remov environment to decrease targe anxiety, or depression. The progress notes for R1 wer 1/1/18-3/21/18, and there were incidence of inappropriate beha R1 was observed periodically t survey on 3/20/18, from 12:30 3/21/18, from 9:00 a.m. to 3:30 from 7:00 a.m3:00 p.m. durin noted that R1 did not move on able to verbalize, and had abso inappropriate behaviors. R1's Consultant Pharmacist Me form dated 8/25/17, indicated t pharmacist had identified R1 h Risperdone 0.25 in the morning daily and requested the physici dose reduction or write a justific clinical documentation regardir benefit of the continued dose. action section indicated the physici dose reduction statement had bee There were no further pharmaci recommendations regarding th 	ncluded ve, and continuous the staff to red, ects and h, report behavior provide non with include 1 to 1 ing resident from et behaviors, re reviewed from e no documented avior for R1. throughout the -8:00 p.m. on 0 p.m. 3/22/18, g which it was her own, was not olutely no edication Review the consultant ad been on g and 1 mg twice ian to attempt a cation providing ng the risk vs The follow-up ysician accepted there is no empted or clinical in documented. cy	F 756			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ID PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	j	CON		
		245323	B. WING		03/27/2018		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X /UU		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 756	Continued From pa	age 181	F 756				
	risperdone, depako facility could not fin	ote, or trazodone. However the d the recommendations from d March 2018 had not yet been					
	3/27/18, at 8:59 a.r pharmacy review in rispersone was for know if that diagno record by the prese the consultant phan been showing sign months. The consu- had no current beh justify the need for depakote and had any of those medic pharmacy review w recommended for of pharmacist stated to recent recommend Free from Unnec P CFR(s): 483.45(c)(F 758			5/6/18	
	affects brain activit processes and beh	ychotropic drug is any drug that ies associated with mental lavior. These drugs include, to, drugs in the following					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING _		03/;	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	Continued From pa	ge 182	F 75	58		
	psychotropic drugs unless the medicati	dents who have not used are not given these drugs on is necessary to treat a s diagnosed and documented d;				
	drugs receive gradu behavioral intervent	dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these				
	psychotropic drugs unless that medicat	dents do not receive pursuant to a PRN order ion is necessary to treat a condition that is documented d; and				
	are limited to 14 day §483.45(e)(5), if the prescribing practitio appropriate for the l beyond 14 days, he rationale in the resid	orders for psychotropic drugs ys. Except as provided in a attending physician or oner believes that it is PRN order to be extended or she should document their dent's medical record and in for the PRN order.				
	drugs are limited to renewed unless the prescribing practitio the appropriateness This REQUIREMEN by:	orders for anti-psychotic 14 days and cannot be attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced ion, interview, and document		This Plan of Correction constitutes	s my	
	review, the facility far received as needed	ailed to ensure residents who		written allegation of compliance for deficiencies cited. However, subm of this Plan of Correction is not an	the	

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PRINTED: 05/04/2018

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		3) DATE SURVE
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	۱G _		COMPLETED
	245323	B. WING _			03/27/2018
PROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
R REHABILITATION &	HEALTHCARE CENTER				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
Continued From pa	ge 183	F 75	58		
medication longer t affected 3 of 3 resid orders for antianxie faciilty failed to ade medications regard need for 5 of 6 resid reviewed for psyche Finding include: R23 utilized a PRN the record did not of use for utilization of 14 days. In additionantide pressant med monitoring for the of medication. R23's quarterly min 3/9/18, identified R2 impairments and di history of stroke an The MDS indicated assistance with all displayed daily vert behaviors towards R23 utilized antidep utilized antianxiety period. R23's annual MDS R23 displayed daily aggressive behavior indicated R23 utilized	han 14 days. This practice dents (R23, R2, R3) with ety medications. In addition, the quately monitor psychoactive ling efficacy and on-going dents (R23, R2, R6, R1, R3) otropic medications. A antianxiety medication and contain a rational or duration of f the medications greater than on, R23 received dication without adequate continued use of the mum data set (MDS) dated 23 with severe cognitive agnoses including dementia, d aphasia (inability to speak). R23 required extensive activities of daily living. R23 oal and physical aggressive others. The MDS indicated oressant medications daily and medication 6 of a 7 day review dated 10/13/17, also indicated overbal and physical ors towards others. The MDS ed antidepressant medications			admission that a deficiency exists or the one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to follo guidelines regarding use of PRN psychotropic medications. For R2, R22 and R3 the facility failed to ensure thes residents who received their prn antianxiety medications had rationale future the 14-day regulation. These medication have been reviewed with pharmacy consultant and recommendations send MD for follow up documentation. The facility also failed to adequately monitor psychoactive medications efficacy and need for R23, R2, R6, R1, and R3. All medications have been reviewed with consultant and discussed at QAPI in A The framework has been set to ensure adequate follow up with dose reduction proper diagnoses, target behaviors pu place on TAR and overall compliance of the 14-day regulation. MAR □s and TAR □s updated and care plans updated. 2. Because many residents have ord for PRN psychotropics, many are potentially affected by the cited deficie staff were reminded to ensure safe environments and necessary intervent to redirect behaviors before utilizing medications if medications are needed	d ow 23, 2se for in ions t to or d April. e ons, ut in with e ders ency, tions
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER REHABILITATION & SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par medication longer to affected 3 of 3 resid orders for antianxie faciilty failed to ade medications regard need for 5 of 6 resi reviewed for psyche Finding include: R23 utilized a PRN the record did not of use for utilization of 14 days. In addition antidepressant med monitoring for the of medication. R23's quarterly min 3/9/18, identified R2 impairments and di history of stroke an The MDS indicated assistance with all displayed daily vert behaviors towards R23 utilized antidep utilized antianxiety period. R23's annual MDS R23 displayed daily aggressive behavior indicated R23 utilized antidep	DEF CORRECTION IDENTIFICATION NUMBER: 245323 PROVIDER OR SUPPLIER REHABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 183 medication longer than 14 days. This practice affected 3 of 3 residents (R23, R2, R3) with orders for antianxiety medications. In addition, the facility failed to adequately monitor psychoactive medications regarding efficacy and on-going need for 5 of 6 residents (R23, R2, R6, R1, R3) reviewed for psychotropic medications. Finding include: R23 utilized a PRN antianxiety medication and the record did not contain a rational or duration of use for utilization of the medications greater than 14 days. In addition, R23 received antidepressant medication without adequate monitoring for the continued use of the medication. R23's quarterly minimum data set (MDS) dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living. R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 day review	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUILDIN 245323 PROVIDER OR SUPPLIER REHABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 183 medication longer than 14 days. This practice affected 3 of 3 residents (R23, R2, R3) with orders for antianxiety medications. In addition, the facility failed to adequately monitor psychoactive medications regarding efficacy and on-going need for 5 of 6 residents (R23, R2, R6, R1, R3) reviewed for psychotropic medications. Finding include: R23 utilized a PRN antianxiety medication and the record did not contain a rational or duration of use for utilization of the medications greater than 14 days. In addition, R23 received antidepressant medication without adequate monitoring for the continued use of the medication. R23's quarterly minimum data set (MDS) dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living. R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 day review period. R23's annual MDS dated 10/13/17, also indicated R23 displayed daily verbal and physical aggressive behaviors towards thers. The MDS indicated R23 utilized antidepressant medications	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245323 REMABILITATION & HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 183 medication longer than 14 days. This practice affected 3 of 3 residents (R23, R2, R3) with orders for antianxiety medications. In addition, the facility failed to adequately monitor psychoactive medications regarding efficacy and on-going need for 5 of 6 residents (R23, R2, R6, R1, R3) reviewed for psychotropic medications. Finding include: R23 utilized a PRN antianxiety medication and the record did not contain a rational or duration of use for utilization of the medications greater than 14 days. In addition, R23 received antidepressant medication without adequate monitoring for the continued use of the medication. R23's quarterly minimum data set (MDS) dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living. R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antianxiety medication 6 of a 7 day review period. R23's annual MDS dated 10/13/17, also indicated R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7	RS FOR MEDICARE & MEDICAID SERVICES OME OF DEFICIENCIES FOR DEFICIENCIES FOR DEFICIENCIES (X1) PROVIDERSUPPLIERCILA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) MULTIPLE CONSTRUCTION A BUILDING 245323 B. WING STREET ADDRESS, GTY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCES (RECHADELITATION & HEALTHCARE CENTER ID PROVIDER NO LSC IDENTIFYING INFORMATION) PROVIDER NO CORRECTIVE ACTOR SHOULD BE CONSTRUCTIVE ACTOR OF CORRECTION (EACH ODERICENCY WIST BE PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 183 medication longer than 14 days. This practice affected 3 of 3 residents (R23, R2, R3) with facility failed to adequately monitor psychoactive medications regarding efficacy and on-going need for 5 of 6 residents (R23, R2, R6, R1, R3) reviewed for psychotropic medications. F 758 Finding include: F 748 admission that a deficiency exists or t one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and redication for the continued use of the medication. F 758 Finding include: F 758 admission that a deficiency exists or t one was cited correctly. This Plan of Continued To synchotropic medications. F 768 Finding include: F 758 admission that a deficiency exists or t one was cited correctly. This Plan of Continued to not contain a rational or duration of the record dia not contain a rational

Facility ID: 00995

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	G		PLETED
		245323	B. WING		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	PCODE	
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST WALKER, MN 56484	Г РО ВОХ 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 758	Continued From pa	ge 184	F 75	8		
	behaviors put hims for injury. R23's Order Summ included an order fo 50 milligrams (mg) for anxiousness and been received on 3 order for Ativan (an administered as ne morning and evenin dose as needed thr was received on 9/7 R23's care plan dat a history of being p dementia. The plan medication as orde side effects and effects R23's clinical recorn behaviors for the us medication. Nor we interventions identifi the medication adm Review of R23's ele administration recorn	The CAA indicated R23's elf and staff members at risk ary Report dated 2/23/18, or Trazodone (antidepressant) to be given daily at beditme d insomnia. The order had /31/17. R23 had a second tianxiety) 0.5 mg to be eded for agitation prior to ng cares with one additional roughout the day. The order 7/17. The d 3/27/17, indicated R23 had hysically aggressive due to directed staff to administer red and monitor/document the ectiveness of the medication. d did not identify specific target se of the PRN antianxiety ere non-pharmacological fied to be attempted prior to ninistration.		 current as needed psychol appropriate use. No other affected. The policy on PF and psychotropic medication reviewed and revised. 3. To enhance currently operations and under the DON, on 5/1/2018 all nurs receive in-service training psychotropic medications PRN for more than 14 day importance of physician do order continued use or so consistently, indicating tar noted in documentation, a non-pharmacological app Psychotropic medications at quarterly and annual re determine need, effective reduction. Effective 4/19/2018, a quality-assurance prograr implemented under the su DON to monitor residents for psychotropic meds. T designated quality-assurar representative will perform systematic audits on reside for prn psychotropic; 50 % weeks, then 25% of resid months to ensure complia 	residents were RN psychotropic tions has been compliant direction of the sing staff will on utilizing PRN that are ordered ys and the loing visit to hedule if needed rget behaviors and roaches. will be reviewed views to ness or dose a m was upervision of the with prn orders he DON or ince n the following dents with orders x 4 ents weekly x 2	
	3/22/18. Review of R23's me of non- pharmacolo	23 doses in 3/18 from 3/1/18 - edical record lacked indication ogical interventions attempted ne PRN medication.		of PRN use as well as respected of PRN use as well as respected on the spot, and the quality-assurance chemical of the spot, and the spot, assurance chemical of the spot of t	to ensure rs and ;ies will be d the findings of	

Facility ID: 00995

						<u>. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	FIPLE CONSTRUCTION	· · ·	E SURVEY IPLETED
		245323	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST I WALKER, MN 56484	PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 758	Continued From pa	ige 185	F 7	58		
	form dated 1/20/18 pharmacist had ide antianxiety medicat a PRN antianxiety r	, indicated the consultant ntified R23's frequent use of tion. The pharmacist indicated medication required the record cumentation from the physican		meeting for further review of action. 5. The Pharmacy, SSC an responsible for this POC.		
	indicated R23 had s the occasional dose did not indicate what	ician replied on 1/26/18, and significant anxiety and required es of Ativan. The physician at type of non pharmacological to be attempted prior to the e medication.				
	warned registered rassisting R23 with a	p.m. nursing assistant (NA)-D nurse (RN)-E that while a meal, if food was spilled on ory to attempting to strike out				
	clinical services (RI record and confirm R23's target behaving the as needed antiar record did not contar PRN ativan for a tir days. Non pharmar been identified and had not been evalue RDCS stated the far	p.m. the regional director of DCS) reviewed R23's clinical ed the facility had not identified iors for the continued use of anxiety medication. R23's ain a rational for the use of the ne period of greater than 14 cological interventions had not the antidepressant medication ated on a quarterly basis. The acility did not have a system to n relationship to their ions.				
	receive assistance	a.m. R23 was observed to with personal cares by NA-B empted to hit and kick at the				

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	On 3/23/18, at 10:3 behaviors included during cares. RN-B a drink or reapproa required a PRN Ativ not have a system pharmacological int administration of th R2 received antipsy adequate monitorin medication. In add medication and the a rational or duratio medication utilized R2's annual MDS d with severe cognitiv including Parkinson anxiety. The asses extensive assistant living and did not di problems. The asses received daily antip medications. R2's Psychotropic N Assessment (CAA) received antipsycho medications and the effects of the medic R2's physician orde order for Seroquel ((mg) twice a day, re mg at bedtime, Pro daily, and Klonopin	 3 a.m. RN-B stated R23's yelling, kicking and pinching of stated staff was to offer R23 ich him. At times, R23 wan, however, the facility did to document non terventions prior to the emedication. wychotic medications without use of the ition, R2 had PRN antianxiety clinical record did not contain on of use for the antianxiety greater than 14 days. lated 11/2/17, identified R2 we impairments and diagnoses n's disease, dementia and essment indicated R2 required be with all activities of daily splay mood or behavior sessment indicated R2 sychotic and antidepressant Medicaiton Care Area dated 11/3/17, indicated R2 bic and antidepressant e staff was to monitor for side 	F	758			

		AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		LE CONSTRUCTION		E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pa	ge 187	F 7	'58	3		
	utilized psychotropid directed the staff to and document, more non-pharmaceutication one on one interver changing position. staff to evaluate for medications.	ed 12/28/17, indicated R2 c medication. The plan monitor for target behaviors nitor R2's behaviors, provide al interventions that included ntions, redirecting and The plan also directed the the effectiveness of the					
	3/21/18, at 11:30 a. receive total assista	s of personal cares on m. R2 was observed to ance with cares from nursing At no time was R2 observed to behaviors.					
	(EMAR) for 1/18-3/ the schedule doses ordered. R2 had no order. The EMAR a documentation rela antidepressant, ant medications. The E displayed any type medications. The E	dication administration record /18, indicated R2 had received s of Seroquel and Remeron as ot utilized the PRN Klonopin also included daily ted to potential side effects of cianxiety and antipsychotic EMAR indicated R2 had not of side effects from the EMAR did not identify R2's a she was receiving the					
	Medication Review the pharmacist had remeron, Prozac or for a dose reduction indicated he/she ag	nsultant Pharmacist form dated 7/20/17, indicated quested if the Seroquel, Klonopin could be considered n. R2's primary physican greed with the pharmacist however, R2's family refused uction.					

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		& MEDICAID SERVICES	0.000				0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY PLETED	
		245323	B. WING			03/2	27/2018	
NAME OF I	PROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 758	 A Consultant Phat form dated 9/19/17 requested non phat attempted prior to a Klonopin and to ide guide the use of the indicated he/she wa recommendation at non pharmacologic the findings. A Consultant Phat form dated 11/21/1 had requested the pharmacological im administration of th indicated target bet the record. The pri agreement with the A Consultant Phat form dated 2/23/18 the PRN Klonopin i questioned if the m discontinued. R2's R2's family member reductions or disco R2's record contain which the primary p evaluated by a mer 	rmacist Medication Review , indicated the pharmacist had rmacological interventions be administration of the PRN entify the target behaviors to e medication. The physican as in agreement with the nd directed the staff to attempt al interventions and document rmacist Medication Review 7, indicated the pharmacist staff to identify the non terventions prior to the e medication. The pharmacist naviors were not identified in mary physican was in e pharmacist findings. rmacist Medication Review , indicated R2 had not utilized n the past month and	F7	758	3			
	indicated during the member was prese hallucinations in the distress during pas	e evaluation R2's family ent and reported R2 displayed e past and had suffered severe t attempts at medication ore, the medications were not						

		AND HUMAN SERVICES			FORM	: 05/04/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	E SURVEY MPLETED
		245323	B. WING		03/	/27/2018
NAME OF	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP COD	=	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO E NALKER, MN 56484	SOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 758	Continued From pa	ge 189	F 758			
	specific types of be the record include a non-pharmacologic the PRN Klonopin v lacked a quantitativ her behaviors in rela- On 3/22/18, at 2:50 stated the facility sta behaviors, monitor monthly evaluation relationship to the m facility did not have the behaviors and a was reviewing the e R2's PRN Klonopin however, R2's powe the medication to be clinical record did n which the risks and had been discussed On 3/23/18, at 10:4 (RN)-B stated R2 d adverse behaviors. R6 received antiany adequate behavior R6's quarterly MDS with moderate cogn diagnoses including atrial fibrillation and MDS also identified having little energy assessment period.	al interventions to attempt if was to be used. R2's record e and qualitative evaluation of ationship to the medications. D p.m. registered nurse (RN)-E aff was to identify R2's target the behaviors and complete a of the behaviors in nedications. RN-E stated the a system in place to monitor at this time no staff member efficacy of the medications. had not been utilized, er of attorney refused to allow e reduced. RN-E stated R2's ot include documentation in benefits of the medications d with the family member. 0 a.m. registered nurse id not display any type of kiety medications, without monitoring. dated 1/17/18, identified R6 nitive impairments and g depressive disorder, chronic mitral valve disease. The R6 as feeling down and				

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING _			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pa activities of daily livi	-	F 75	58			
	as having little to no feeling down and do about herself on 2-6 period. R6 did not	OS dated 6/29/17, identified R6 o interest in doing things, epressed and feeling bad 6 days during the assessment display any type of adverse ne of the assessment.					
	indicated R6 utilized anxiety and Zoloft (AA directed the staff to monitor					
	included an order for The Buspar was sta depressive disorder	ary Report dated 3/5/18, or Buspar 10 mg every day. ared on 10/17/17, for "major r." R6 also had an order dated 20 mg daily for the treatment e disorder.					
	administer medication for side effects. R6	ed 12/1/17, directed the staff to ions as ordered and monitor 's care plan did not identify r the continued use of the tions.					
	3/27/18, R6 was no of behaviors. For e p.m. R6 was observe eating the noon me residents, converse when she was throu herself out of the di	-					
	Review of R6's EM	AR's for January, February					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	and March 2018, in generic symptoms of hopelessness, anxi anorexia, verbalizin repetitive anxiety ar indicated R6 never aforementioned cor identify specific indi R6. R6's Behavioral He Report dated 3/15/7 antidepressant med 1/18, from Zoloft to the psychiatric nurs reduce R6's antiany to monitor R6's antiany to monitor R6's antiany to monitor R6's entiany to monitor R6's pro- 3/21/18, revealed n evaluation. Review of R6's Pro- 3/21/18, revealed n evaluation of R6's be antidepressant med 1/18/18. The notes analysis of R6's be treated with of the a On 3/22/18, at 2:50 staff was to identify the behaviors and c of the behaviors in medications. RN-E a system in place to this time no staff medications.	dicated staff monitored R6 for of depression including ety, sadness, insomnia, g negative statement, ind tearfulness. The EMAR's displayed any of the incerns. The EMAR did not vidualized target behaviors for alth Psychiatric Progress 18, indicated R6's dications had been changed in Celexa. Due to the change, e practitioner had opted not to kiety medication and continue depressant medications. R6 behaviors at the time of the gress Notes dated 1/8/18, - o documentation of an behaviors after the dications were changed on also lacked a comprehensive naviors/symptoms being antianxiety medication. p.m. RN-E stated the facility R6's target behaviors, monitor complete a monthly evaluation relationship to the stated the facility did not have o monitor the behaviors and at ember was reviewing the factions. 0 a.m. RN-D stated R6 did not	F	758			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245323	B. WING_			03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	' 00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	R1 received multipl without an appropri monitoring, or justif R1's quarterly MDS with severe cognitiv including Alzheimer pressure, and type indicated R1 require all activities of daily or symptoms of psy verbal or physical a others. The MDS is antipsychotic and a daily. R1's Psychotropic II Assessment (CAA) utilized antipsychotic medications daily w risperdone, and traz- indicated R1 had ar R1's Order Summa not provided. Review of R1's medications antipsychotic medic day and 1 mg twice behavioral disturbativ was not found in the with staff) and rece (mood stabilizer) 12 restlessness and ag Trazodone (antidep	e psychotropic medications ate diagnosis, adequate fication for continued use. 6 dated 12/27/17, identified R1 ve impairments and diagnoses r's disease, high blood II diabetes. The MDS ed extensive assistance with r living. R1 displayed no signs vchosis or delirium and had no aggressive behaviors towards indicated R1 utilized intidepressant medications Drug Use Care Area dated 11/3/17, indicated R1 ic and antidepressant vhich included the medications zodone. The CAA had not my inappropriate behaviors. ary Report was requested but dication administration record dicated R1 received the cation risperdone 0.5 mg every a day for dementia without nce since 5/17 (exact date e record or through interview ived Depakote Sprinkles 25 mg since 1/16/18, for gitation. R1 received pressant) 25 mg to be given nentia with behavioral	F 7	58			

Facility ID: 00995

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		(X3) DA1	<u>. 0938-039</u> E SURVEY IPLETED
		245323	B. WING		02	/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03	21/2010
WALKE	R REHABILITATION &	HEALTHCARE CENTER		700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 758	R1's care plan date indicated R1 target wandering, being u pacing. The care p medication as orde side effects and eff report behavior cha provide non pharm include 1:1 activity, resident from envir behaviors, anxiety, R1's Consultant Ph form dated 8/25/17 pharmacist had ide Risperdone 0.25 in daily and requested dose reduction or v clinical documentation benefit of the contin action section indic the recommendations risperdone, depako facility could not fin 2/18, and 3/18, had The progress notes 1/1/18-3/21/18, and incidences of inapp R1 was observed p survey on 3/20/18, 3/21/18, from 9:00 from 7:00 a.m3:00	ad last revised 12/28/17, behaviors included ncooperative, and continuous lan directed staff to administer red, monitor/document the fectiveness of the medication, anges to the physician, and acological interventions with redirecting, and removing onment to decrease target or depression. marmacist Medication Review , indicated the consultant entified R1 had been on the morning and 1 mg twice d the physician to attempt a write a justification providing tion regarding the risk vs nued dose. The follow-up eated the physician accepted on, however there was no tion was attempted or clinical ent had been documented.	F 75	58		

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES		тіс			0938-0391
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		PLETED
					·		
		245323	B. WING			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7	'00	
					WALKER, MN 56484		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI)	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
- 750							
F 758		•	F 7	'58	3		
	to verbalize, and ha	ad no inappropriate behaviors.					
	On 3/26/18, at 9:54	a.m. the regional director of					
		DCS) reviewed R1's					
	medication record a	and progress notes and					
		ot have appropriate diagnoses					
	for the use of risper progress notes had	rdone and depakote. R1's					
	1 0	vior symptoms R1 had					
		18-3/22/18, and wandering					
	and pacing is not a	ppropriate indications for the					
	use of risperdone,	trazodone, and depakote.					
	R3's as needed (PF	RN) Ativan lacked duration and					
		cian rational for exceeding					
	beyond a 14 day du	uration. R3's face sheet dated					
		iagnoses of asthma and					
	chronic respiratory	failure.					
	A communication n	ote from the hospice service					
		d 2/26/18, requested R3's					
	scheduled Ativan (a	antianxiety) 0.5 mg every four					
	0	to 0.5 mg PRN every four					
		scheduled dose caused					
		ess. The physician's response ion identified agreement and					
		tivan to 0.5 mg every for hours					
		ety. The order lacked a					
	duration for use. R3	3's record lacked evidence of a					
		ion to extend the duration for					
	use of the Ativan be	ayond 14 days.					
	R3's medication ad	ministration record (MAR)					
		3/1/18, and 3/23/18, Ativan 0.5					
	mg was administere	ed on 40 occasions.					
	$O_{\rm P} 2/22/19$ at 10.1	2 a m. registered pures					
		2 a.m. registered nurse le physician should have					
		onal and a duration for the PRN					

Facility ID: 00995

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PRINTED: 05/04/2018

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUITIP		B NO. 0938-039 (3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED	
		245323	B. WING		03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 758	-	-	F 758	3		
	physician was resp	I she thought the hospice onsible for ensuring entation for PRN psychotropic				
	indicated PRN psyc	7 a.m. the administrator hotropic medication beyond physician justification and				
F 810 SS=D	Region policy and p identified the facility comply with state a to the use of psyche to include regular re appropriate dosage benefits. Additional of determining the u symptoms so the a environment, medic interventions, as we medications can be Assistive Devices -	e Management Minnesota procedure dated 12/23/17, y will make every effort to nd federal regulations related opharmacological medications eview for continued need, s, side effect, risks and/or ly, the facility supports the goal underlying cause of behavioral ppropriate treatment of cal, and/or behavioral ell as psychopharmacological e utilized. Eating Equipment/Utensils	F 810		5/6/18	
	and utensils for res appropriate assista can use the assistiv meals and snacks.	e devices ovide special eating equipment idents who need them and nce to ensure that the resident ve devices when consuming NT is not met as evidenced				
	Based on observat review, the facility	ion, interview and document ailed to provide adaptive ote independence with eating (R23) reviewed for nutrition		This Plan of Correction constitutes n written allegation of compliance for th deficiencies cited. However, submiss of this Plan of Correction is not an	ne	

Facility ID: 00995

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		AND HUMAN SERVICES				FORM	05/04/201 APPROVE <u>0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 810	Continued From pa	nge 196	F8	310			
	•	/ difficulty eating and drinking.			admission that a deficiency exists	or that	
	Findings include:	, , , ,			one was cited correctly. This Plan Correction is submitted to meet	of	
		imum Data Set (MDS) dated			requirements established by state federal law.	and	
	3/9/18, identified R	23 with severe cognitive			1. It is the policy of the facility to		
		agnoses including dementia,			adaptive equipment to all residents		
		d aphasia (inability to speak). R23 required extensive			conjunction with OT to ensure resi remains as independent and high	dent	
		activities of daily living			functioning as they can. R23 was r	noted to	
	including eating.	, .			have divided plate in his care plan	but not	
					on diet card as dietary manager st		
		dated 10/13/17, also identified tensive assistance with			had been discontinued and R23 w noted to have very difficult time rea		
	eating.	densive assistance with			table and food due to chair and sp		
					most of his beverage. Although sp		
		tatus Care Area Assessment			covered cup is in his room a cover		
		/17, indicated R23 displayed			was not available for meal service.		
		s and threw food during meals. l of check marks for the			evaluation for more appropriate cu divided plate will be put back on di		
		t no compressive assessment			and covered cup used in dining roo		
	of R23's nutritional				2. Because all many residents ne		
					adaptive devices many are potenti		
		Data V2.1 form dated			affected by the cited deficiency. The		
	equipment during n	R23 did not require adaptive			discussed with dietary manager ar dietician and it is agreed the diet s		
	equipment during in				be updated when appropriate cup		
	R23's Care Plan da	ated 1/20/18, indicated R23			determined and in meantime staff		
		e guard for meals to ensure			encourage with assisting and utiliz		
		t greater than or equal to 75%			divided plate and finger food type i		
	of the meal.				All residents with adaptive devices been reviewed for use and	nave	
	On 3/19/18, at 10.4	47 a.m. family member (FM)-B			appropriateness. No other residen	ts were	
		to be very thirsty when FM-B			affected.		
	visited the facility.	FM-B stated she had brought			3. To enhance currently compliar		
		to use in his room but was			operations all staff will be updated		
		were allowing R23 to use the			in-service 5/1/2018 about adaptive		
	cup.				equipment and importance of offer alerting charge nurse if further follo		

Facility ID: 00995

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
		245323	B. WING		03/	27/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	•	21/2010	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE W WALKER, MN 56484	VEST PO BOX 700	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 810	On 3/19/18, at 12:0 the dining room in a R23's wheelchair w was positioned perp wheelchair was too - At 12:07 p.m. R23 thickened juice and glass. R23 was ob- his shirt as he was lips without spilling. - At 12:10 p.m. R23 glass, attempt to dr - At 12:12 p.m. fam unidentified staff me himself. FM-A state to do that before." - At 12:15 p.m. R23 spilled the juice ont - At 12:17 p.m. nurs R23 the noon meal and fruit. R23's pla equipped with a pla feed R23 with the n - At 12:32 p.m. R23 of the meal with the continued to indeper attempted to drink, his shirt. On 3/20/18, at 12:5 the dining room. R sloppy Joe (sandwi beans and fruit. R	5 p.m. R23 was wheeled into a tilt and space wheelchair. as in a reclined position. R23 bendicular to the table as his high to fit under the table. 3 reached for a glass of attempted to drink from the served to spill the juice onto not able to get the glass to his 6 continued to pick up his ink and spilled onto his shirt. ily member (FM)-A asked an ember if R23 was able to feed ed "I have never seen him try 8 again picked up his glass and o his shirt. sing assistant (NA)-C served consisting of ham, potatoes te was not observed to be te guard as NA-C began to neal. 6 had eaten approximately 1/3 e assistance of NA-C. R23 endently pick up his glass, causing the liquid to spill onto 0 p.m. R23 was observed in 23 had a meal consisting of ch on a hamburger bun) green 23 was observed to hold the ind and eat it independently. assist R23 with the other meal	F 81	 needed to find another respect and dignity wigiving residents the to successful in their AD 4. Effective 4/17/20⁻ quality-assurance proimplemented under the dietary manager to missistance. The dieta designated quality-assurance presentative will per systematic changes: for all meals during fir audits per resident per then 1 audit x2 monther compliance in this are will be corrected on the findings of the quality-assurance will be documented at monthly quality-assurance for further resident. 5. All staff will be resident per the first will be resident per the the the the the the the the the the	th and importance of pols they need to be L's. 18, a gram was ne supervision of the onitor adaptive a needing ary manager or surance form the following the dietary manager udits on residents or needing devices st week then 3 or week x 4 weeks, as to ensure ea. Any deficiencies ne spot, and the assurance checks and submitted at the ance committee view or corrective		

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		X3) DATE (<u>)938-039</u> survey	
	OF CORRECTION	IDENTIFICATION NUMBER:	` ´	NG	````````````````````````````````	COMPL		
		245323	B. WING _			03/27	7/2018	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CIT	TY, STATE, ZIP CODE			
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AV WALKER, MN 564	'ENUE WEST PO BOX 70 84	(700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD E RENCED TO THE APPROPRI DEFICIENCY)	-	(X5) COMPLETIO DATE	
F 810	Continued From pa	age 198	F 81	10				
	· ·	aten 100% of the sandwich and						
		ieal items. R23's shirt was						
		was observed to be seated						
		e dining room. A glass of						
		s observed on the table, which began drinking. R23's						
		a semi-reclined position as he						
		from the glass. R23 was						
		small portion of the juice onto						
	his shirt.							
) served R23 a meal						
		noodle casserole, peas and a ras not observed to be						
		as not observed to be						
		23's wheelchair so he was able						
		d repositioned the wheelchair						
	into an upright posi							
		picked up his spoon and						
	began to feed hims							
		attempted to drink a glass of down himself and onto the						
		ss hit the floor, R23 began to						
		is fingers. R23 was observed						
		it amount (greater than 1/2 of						
		himself, the table and the floor						
		was not observed to assist						
	R23 with eating the	tered nurse (RN)-E asked						
		assist in the dining room.						
		E to assist R23 and warned						
	RN-E that if the foc	d was spilled on R23, he had						
		out at the staff. RN-E sat next						
		the table was too low for R23						
		E then reached under the table I of the table by cranking a						
		edestal stand. R23 was then						
	positioned under th							

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 810	Continued From pa without over extend - At 5:30 p.m. R23 I 25% of of his meal spillage noted on th R23 was not recept assist him with the On 3/21/18, at 12:1 the dining room. N R23's plate was not guard. NA-B was of feed him the meal. - At 12:29 p.m. the any type of adaptive was identified on th Review of R23's die type of adaptive equilation had an order for a p was discontinued a at the time, R23 was himself. The DM st documented the dis guard. The DM cor himself the past few provided. The DM a utilized covered cup covered up in his ro members. The DM R23's ability to drint to be evaluated for at meals. Review of R23's clint documentation relat the plate guard.	ge 199 ling his arms. had finished approximately with a significant amount of the floor, R23 and the table. tive to RN-E's attempts to meal. 5 p.m. R23 was observed in A-B served R23 the meal. t observed to have a plate observed to sit next to R23 and dietary manager (DM) stated the equipment required at meals the resident dietary card. etary card did not identify any upment. The DM stated R23 olate guard in the past, but it bout six weeks ago because to not attempting to feed tated the nurses should have scontinuation of the plate of firmed R23 had been feeding w days and a lip plate was not also stated R23 had not os at meals, but did have a bom brought in by the family stated she had not noticed k and had not requested R23 additional adaptive equipment	1	310			
	stated she was una equipment R23 was	ware of the type of adaptive s to be utilizing at meals. To staff member or family					

Facility ID: 00995

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	· · ·	E SURVEY
D PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		IG	COM	IPLETED
		245323	B. WING _		03/	27/2018
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	OX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 810	member had reque	ge 200 sted R23 to be evaluated for equipment. The DON stated	F 81	0		
	she would review R information related	23's record for further to the plate guard to her knowledge, no				
F 835	requested and not	daptive meal equipment was provided.	F 83	35		5/6/18
	enables it to use its efficiently to attain of practicable physical well-being of each r This REQUIREMEN by: Based on observat review, the facility fa administrative overs residing in the facilit	dministered in a manner that resources effectively and or maintain the highest l, mental, and psychosocial resident. NT is not met as evidenced ion, interview, and document ailed to ensure adequate site for all 23 residents y. The systematic lack of		This Plan of Correction constitu written allegation of compliance deficiencies cited. However, sub of this Plan of Correction is not a	for the mission an	
	5 resident related to 28 residents residin influenza season id prevention. The fac comprehensively as implement intervent infection control me potential serious has	immediate jeopardy's (IJs) for o accident prevention and all ng in the facility during the entified for infection control cility's systemic failure to assess and effectively tions to prevent accidents and easures could have resulted in rrm, injury, impairment or potential to affect all 23 in the facility.		 admission that a deficiency exision was cited correctly. This Placorrection is submitted to meet requirements established by stafederal law. 1. It is the policy of the facility tadequate oversite for all 23 resideresiding in the facility. Lack of soversite resulted in immediate jefor 5 residents related to accident prevention and 28 residents residents residents residents resident the facility during the influenza so related to infection control. This 	an of te and o ensure dents ystemic copardies nt ding in eason	

Event ID: RI9311

Facility ID: 00995

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	TIPLE CONSTRUCTION		E SURVEY PLETED
		245323	B. WING		03/2	27/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	O BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 835	Continued From pa	ge 201	F 8	35		
	stated she had assi the administrator ro she had identified s facility. The administ contacted the regio (RDCS)-B and the o officer (COO) regar The administrator s been communicate had not been estab Multiple systemic an immediate jeopardy recertification surve immediate jeopardy F689 related to resi any other exit seeki began on 3/21/18, at 3/27/18, at 12:00 p. an elopement risk a and developed and and procedures rela and safety. F689 related to a sy comprehensively as mechanical lifts to e receive injuries whil included R2. The IJ removed on 3/27/18	0 a.m. the facility administrator umed the responsibilities for le on 1/18/18. At that time, ystem failures within the strator indicated she had nal director of clinical services corporate chief of operations ding the identified concerns. tated the system failures had d, however, corrective plans lished to achieve compliance. Ind care related issues and d's were identified during the ey. The following were the d's: dent elopement for R226 and ng residents. The IJ which at 10:01 a.m, was removed on m. when the facility completed assessment on all residents implemented improved policy ated to resident elopement dest to resident elopemen		 serious harm, injury, impairr The vacant position of RDC filled and additional support has been established for fac Administration communicati of the present system failure systems and current suppor be needed. COO acknowle supported in getting addition resources and support to as that were identified to need Systemic failures were ident corrective actions were take residents at risk and steps to prevent reoccurrences. 2. This deficient practice c residents who reside in the failures were review systems implemented and n 4/18/2018 the Administrator DON and RDCS reviewed e for DON to report and review related concerns and questi RDCS or mentor DON as id Administrator to consult with report identified areas to CC overseeing facility on-site ar providing increased assistar monitoring to facility to ensu- with identified areas of concerns 	S has been and guidance cility. on to the COO es, lack of t that would dged and hal needed sist in areas support. tified, in to identify all aken to an affect all facility. ompliant rection of the cility policies ved, revised, nonitored. On , DON, mentor xpectations w all nursing ons with entified. n RDCS and DO. RDCS nd off-site, nce and re compliance	
	F689 related to a sy	stematic failure to identify and		and COO have also provide support from other facilities company to timely and effici and update areas identified	within ently review facility. Nurse	
		ssess the use of a full body nsure the staff members were		management from other SN assigned to assist on-site ar		

Facility ID: 00995

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION		0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:	• •	NG		PLETED	
		245323	B. WING _			27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
NALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE W WALKER, MN 56484	EST PO BOX 700	(700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE	
F 835	Continued From pa	ae 202	F 83	35			
F 033	utilizing the appropri during transfers for transferred with one resulting in the pote impairment or deat began on 9/15/17, a at 12:00 p.m. after comprehensive ass interventions for lift F689 related to a sy comprehensively as implement fall inter the risk for serious had repeated falls a resulting in the pote impairment or deat was removed for R after the facility con for falls and develo F689 related to a sy comprehensively as implement fall inter the risk for serious syncope episodes of resulting in the pote impairment or deat that began on 9/15/ 3/22/17, at 12:08 p. at 12:00 p.m. after removal plan that in F880 related to a sy maintain an ongoin	riate number of staff members R18 who was observed to be e staff member in the lift, ential for serious harm, injury h. The immediate jeopardy and was removed on 3/27/18, the facility completed a sessment with individualized transfers. ystematic failure to ssess and effectively ventions in order to minimize injury or death for R14 who and a cervical fracture ential for serious harm, injury, h. The immediate jeopardy 14 on 3/27/18, at 12:00 noon nprehensively assessed R14 ped appropriate interventions.	F 83	mentoring to facilities of will assist in support wi implementing, maintain systems to meet requir compliance and reside Health has been conta facility to review syster opportunities for impro support to assure syste and functioning. COO DON to attend a DON her in her new role. Ar and MDS Coordinator additional clinical supp Through these addition DON will be able to en needs are maintained practicable level. SSC consulting services thr individuals within comp attending off-site trainin RDCS presently overse facility systems and in communication with DO Administrator in review identifying and monitor support needed and th progress and findings reviewing and communi information with govern assure compliance.	ith developing, ning and sustaining rements of nt needs. Stratis cted to assist ns, help identify vement and ems are in place approved for the training to assist nother SNF □ s DON also assisting with ort on and off-site. nal services, the sure residents at the highest also receiving ough experienced oany to assist and is ng and mentoring. eeing nursing constant ON and ving systems, ing systems, ing systems and en reviewing with COO. COO is nicating this ning board to administration of the nt needs to be a facility to use its nd to efficiently highest level of		

Facility ID: 00995

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TATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
			A. BUILD	NG	
		245323	B. WING		03/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	
WALKE	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	BOX 700
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET
F 835	Continued From pa	age 203	F 8	35	
	the potential to affet the facility at the tir the facility failed to precautions were in were infected with contact precautions appropriate infection laundry. This practi- all 23 residents res- related to infection initiation of isolation The IJ was remove when facility policies reviewed, revised, were educated on the performance impro- ineffective from 9/2 which it failed to ide improvement and of plans with goals ar compliance. The fa- lead to multiple system timely assistance w to the residents' as by the care plan. T had the potential to resided in the facility	ect all 28 residents residing in ne of the outbreak. In addition, ensure appropriate isolation nitiated for R5 and R24 who organisms which required s. The facility failed to maintain on control practices in the main ice had the potential to affect iding at the facility. The IJ control practices and the n precautions began on 1/5/18. ed on 3/27/18, at 12:00 p.m. es and procedures were and implemented and all staff the changes. c issues included: equality assurance weenent (QAPI) committee was 2017 through 1/17/2018, in entify opportunities for develop measurable action ad plans to monitor for actility's PAST non-compliance stem failures. to the facility failed to ensure nt staffing was available in activity programs, and provide with personal cares according sessed need and as directed his practice was systemic and o affect all 23 residents who ty.		communication from Adminis COO, as well as DON to RD has been created to identify facility will be expected to rep review with RDCS and COO at the time of incident or dete review, and submitted weekl weeks then monthly for 4 mo Minutes and supporting docu QAPI meetings, as well as ai will be sent for review to RDO and will be monitored until su that shows consistent substa compliance with the regulation has been determined from a representative of the regional team feels it is no longer need time reporting and communite continue based on company 5. The Administrator will be for this POC.	CS. An audit areas that the port and of, updating ermination to y for 16 onths. Imentation of hy Ad Hocs CS and COO, ich a time intial ons and until it I executive eded. At that cation will expectations.

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	05/04/2018 APPROVED 0938-0391
	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245323	B. WING			03/2	27/2018
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABILITATION & HE	ALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	700	
PREFIX (EACH DEFICIENCY MU	VENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 and procedures for idereporting, and investigation abuse, elopement, and source. Multiple harm level defindentified including: F686 in which the facil appropriate assessme interventions to prever pressure ulcers for 4 or R2, R23) in the sample ulcers. The facility's fail monitor and/or implement in actual harm for R5 will ulcers while at the facility recurrent pressure ulcer for the decline in range of 2 of 5 residents (R5, R decline in ROM which assessed to be to be ulcers and/or arran council, and provide th 1 of 1 resident (R21) with matters pending in council. 	ropriation of resident he facility lacked polices entification, protection, ating resident to resident d injuries of unknown ficient practices were lity failed to provide ent, monitoring and ht the development of of 6 residents (R5, R18, e who had current pressure ilure to adequately assess, hent interventions resulted who developed pressure lity and for R18 who had ers. failed to provide range of ected in order to prevent f motion (ROM) abilities for 82) observed to have had a was not identified nor unavoidable. lity failed to provide angements to obtain legal herapeutic conversation for who had urgent legal urt. ry of Email communications ator and corporate staff information:	Fε	335			

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		AND HUMAN SERVICES				FORM): 05/04/2018 / APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·			(X3) DA	D. 0938-0391 TE SURVEY MPLETED
		245323	B. WING _			03	/27/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX ALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 835	Continued From paregarding general of Phase 2 requirement Federal regulations - 1/20/18, email serregarding the facility nursing (DON) in neelectronic medical regulations and nursing serregarding the facility of additional training for the DON and nursing serregaredness. - 1/25/19, email serregaredness. - 1/25/19, email serregaredness. - 1/31/18, email to Cadministrator's apprendeness. - 1/31/18, email to Cadministrator's apprendeness. - 2/9/18, email to Resupport to the DON - 2/16/18, email to Castaff members from facility be allowed to regarding PCC. Als the DON, business coordinator and act exposed to the survadministrator requestaff regarding falls, treatments and gen On 3/26/18 at 1:00	age 205 compliance concerns related to ints of the updated CMS and to RDCS-B and COO y's newly hired director of eed of training for the record system (Point Click ested additional training for the taff. In to COO requesting support inimum Data Set (MDS) nurse ing and to assist with survey COO notifying him of the roved shared licenses es. DCS-C requesting additional I in training. COO and RDCS-C requesting in the administrator's second is assist with staff training so expressed concerns that office manger, social service tivity director had not been vey process. The ested additional training for , skin /wound documentation, heral documentation. p.m. the administrator stated	F 83	35			
	the emails through acknowledged the c	and RDCS-C responded to discussions in which they concerns of the facility but did istrator to move forward with					

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		AND HUMAN SERVICES				FORM	: 05/04/201 APPROVE . 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION		TE SURVEY MPLETED	
		245323	B. WING	i		03/27/2018		
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BO /ALKER, MN 56484	DX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 835	Continued From pa	ge 206	F 8	335				
	any plan for assista	ince.						
	A policy related to a but none was provi Governing Body CFR(s): 483.70(d)(F٤	337			5/6/18	
	body, or designated governing body, the establishing and im	facility must have a governing d persons functioning as a at is legally responsible for plementing policies regarding nd operation of the facility; and						
	administrator who is (i) Licensed by the required;	State, where licensing is						
	and (iii) Reports to and governing body.	management of the facility; is accountable to the NT is not met as evidenced						
	the governing body report of the facility lack of facility syste governing the facilit quality of care and	<i>y</i> , the facility failed to ensure acted on the administrator's 's systemic failures related to ms and policy/procedures ty's functioning to ensure quality of life for the residents. tial to affect all 23 residents e facility.			This Plan of Correction constitu written allegation of compliance deficiencies cited. However, sub of this Plan of Correction is not a admission that a deficiency exis one was cited correctly. This Pl Correction is submitted to meet requirements established by sta federal law.	for the omission an ts or that an of		
		ide to reach the president of (PGB) via telephone prior to 3/27/18, which was			 It is the policy of the facility that a governing body is responsestablishing and implement policy of the facility, as well as appointing and facility, as well as appointing and facility. 	sible for cies ement of		

Facility ID: 00995

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		IDENTIFICATION NONIBER.	A. BUILDIN	G		
		245323	B. WING		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 837	Continued From pa	ge 207	F 83	7		
	unsuccessful, hower return telephone ca governing body was at 11:20 a.m At tha governing body was systems issues ident facility that included and implementation systems, and lack of implementation. The was purchased in 2 period that ended of the company had p and by 11/17, the P homes had major s the homes were eith mismanaged. The F were taken to reest facilities were gettin positions, front line positions. At the sam policies and proced consistent with the currently working or policies and proced governing body was failures, but there w could not come into recertification surver working hard to reb and operations to b federal and state ref Review of the Gove dated 11/3/17, reve the lack of sufficien and process improve	ever, a message was left for a II. The president of the stelephoned again on 3/28/18, at time, he was asked if the saware of the multiple ntified during the survey of the lack of: policy development h, staffing, infection control of abuse and neglect policy e PGB stated when the facility /17, there was a transition n 6/30/17. The PGB stated urchased nine homes together GB realized all nine of the ystemic issues, and all nine of her unmanaged or PGB stated the first steps that ablish healthy working ng staff hired into management positions, and consultant me time staff was being hired, ures were being developed regulations. They were n implementation of those ures. The PGB stated the saware of the total systemic vere so many issues they o compliance by the time the ey had taken place. They were uild the facility's management e in compliance with the	ΓΟJ	 administrator who is licensed, rest for management and expected to and be accountable to the govern body. The facility failed to ensure governing body acted on the administrator is report of the syst failures related to lack of facility is policy/procedures that governed t facility is functioning to ensure qu care and quality of life for all reside During survey, the areas identified Administrator were reported and r with the Governing Body, who act immediately upon these and plans implemented to support facility to quality of care and quality of life for residents. The systemic failures widentified, corrective actions were identify all residents at risk and st taken to prevent reoccurrences. This has the potential to affect residents who reside at the facili 3. To enhance currently complia operations and under the direction Administrator, facility policies and procedures were reviewed, revise systems implemented and monito 4/23/18 a process was implemented and monito 5/23/18 a process was implemented for COO immediately with present for COO immediately with present for COO immediately with present MDH at facility, survey results, all of abuse or neglect, complaints, reportable events, upon identifying 	report ing the emic ystems, he lality of ents. d by eviewed ed s were ensure or the were taken to eps t all ity. nt of the ed, or is to dy s and y to the ification e of egations	

Facility ID: 00995

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STATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245323	B. WING		03/	27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION 8			X 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 837	Council Review, P Unplanned Hospita governing board as	hase 2 requirements, and alizations. Additionally, the sked all locations to report, infection control practices	F 83	 7 as staffing, and update status of instances for quality assurance p monthly at a minimum. The Adm is also responsible and held accert to report information indirectly to governing body through the COC audits, open staffing positions ar recruitment and retention plan, s needed for facility to meet reside which is done as determined why systems fall outside of budgeted expectations or deemed necessa meeting resident needs for qualit purposes and updating of chang to facility assessment at time of COO is reviewing and communic information with governing board assure compliance. 4. To assure proper administrat facility, proper oversight needs to resources effectively and to effic ensure the resident s highest le physical, mental and psychosoci well-being are attained or maintat This will be monitored to ensure communication of identified area from Administrator to Governing Board thr notification to COO, including resto assure facility has an active ge body. An audit has been created identify areas that Administrator expected to report to the Govern Board, and submitted to the COC review weekly for 16 weeks then for 2 months. Minutes and supp documentation of QAPI meeting: 	burposes hinistrator buntable the D of d upplies nt needs en ary for ty of life es made change. cating this I to tion of the D be use its iently to vel of al ined. direct s occur Board, as cated ough sponses bverning I to will be ing D for monthly orting	

Facility ID: 00995

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		AND HUMAN SERVICES			FOR	D: 05/04/2018 MAPPROVED D: 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·			TE SURVEY MPLETED	
		245323	B. WING		0	3/27/2018	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 837 F 841 SS=F	Continued From pa Responsibilities of I CFR(s): 483.70(h)(- Medical Director	F 8		as any Ad Hocs will be directly emailed to COO and governing board, and will be monitored until such a time that shows consistent substantial compliance with th regulations and until it has been determined from a representative of the regional executive team that it is no longe needed. At that time reporting and communication will continue based on company expectations. 5. The Administrator will be responsible for this POC.	e	
	 physician to serve a §483.70(h)(2) The normal for- (i) Implementation (ii) The coordination This REQUIREMENT by: Based on interview medical director fail and procedures have implemented to ensist this deficient practical 23 residents who findings include: The facility medical on 3/26/18, at 11:43 she made rounds a 	facility must designate a			This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure that the facility has a medical director wh is responsible for implementation and helping evaluate resident care policies		

Facility ID: 00995

						B NO.		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>		SURVEY PLETED	
		245323	B. WING _			03/2	7/2018	
NAME OF	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 ALKER, MN 56484	PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 841	 ¹¹ Continued From page 210 any time, and attended the quality assurance meetings at least every three months. The MD stated she was involved with developing and implementing quality action plans for sufficient staffing, and stated a large portion of the issues in the facility were related to the rapid turn over in both front line staff and management staff. The MD stated she was very involved in the influenza outbreak that had occurred in January, but was not aware staff was not wearing proper personal protective equipment (PPE) to minimize the spread of infection to other residents. The MD was not aware if the facility had proper infection control policies developed and implemented. The MD stated falls were reviewed at every QAPI meeting, however was not aware if the facility had proper policies and procedures to follow so fall risks were minimized. Review of all the facility policies for infection control, abuse prohibition, falls, use of mechanical lifts, pressure ulcers, psychotropic medication monitoring, resident rights, admission transfer & discharge, and dignity, revealed none had been signed indicating approval by the medical director. The regional director of clinical services was interviewed on 3/26/18, at 1:26 p.m. and confirmed the medical director had not reviewed and approved any of the aforementioned policies. 		F 84	41	and coordination of medical care in the facility. The facility failed to meet this requirement by the medical director failure to ensure the facility policies a procedures had been developed and implemented to ensure quality of resist care. QAPI met on 2/20/18 where it identified by Administrator that presens system was not reviewing operations identifying OFIs, prioritizing OFIs, determining the root cause and implementing PIPs. In discussion wit Medical Director and QAPI members was determined and reviewed that Q had previously been ineffective. Administrator educated everyone on QAPI program, the guidelines, proce and how to analyze data, etc. to begi effectively address systemic failures improve quality at facility. On 4/17/18 was identified by Administrator via pla correction that Medical director review policies, for infection control, abuse prohibition, falls, use of mechanical line	s and d ident was ent s, th s, it API the esses in to to 3 it an of ew of		
					pressure ulcers, psychotropic medica monitoring, resident rights, admission transfer and discharge, and dignity he not occurred and an Ad Hoc was initi on 4/17/18 to assure that the medica director is involved in development, r and approval of resident care policies including their input specific to our resident population and facility needs Specific review of these policies also includes quality assurance members will be brought for further discussion review at next QAPI scheduled on 5/15/2018. 2. This has the potential to affect al	n iated al review s by s. s and and		

Facility ID: 00995

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION ()		SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 /ALKER, MN 56484	PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 841	Continued From pa	age 211	F	341	residents □ who reside at the facility. 3. To enhance currently compliant operations and under the direction of Administrator, facility policies and procedures were reviewed, revised, systems implemented and monitored After identification of ineffective QAP program, education was provided an reviewed by the Administrator during 2/20/18 QAPI. Areas reviewed were to identify the elements and goals of QAPI program, assistance and tools accurate data review, and proper identification of root cause while assi goals are SMART (specific, measura attainable, realistic and time oriented Medical Director contract was review Administrator and Medical Director o 4/17/2018; discussed expectation tha Administrator must ensure all responsibilities of the Medical Director effectively performed to ensure resid attain or maintain their highest practi physical, mental, and psychosocial well-being in accordance with regular guidelines and responsibilities outline Medical Director on the agreed contrr 4. To assure the facility has a media director who is helping to evaluate resident care policies, implementatio and coordination of medical care in the facility; the Administrator or designeer conduct weekly audits to assure that facility is effectively communicating a properly notifying the Medical Director resident events, collaborating on are concern and timely responses from Medical Director are occurring. Audii include monthly participation of QAP	f the d. Pl d g the e how the for uring able, d). ved by on at or are dents icable itory ed for ract. icable itory ed for ract. icable itory ed for ract. icable itory ed for ract. icable itory ed for ract. icable itory ed for ract. icable itory ed for ract. icable itory et for ract. icable itory itor of ract of ract. itory itor of ract itory itor of ract itory itor of ract itory itor of ract itory itor of ract itory itor of ract itor itor of ract itor of ract itor of ract itor itor of ract itor itor of ract itor itor of ract itor itor itor of	

Facility ID: 00995

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	D: 05/04/2018 MAPPROVED O. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			ATE SURVEY OMPLETED	
		245323	B. WING			03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	CFR(s): 483.20(f)(5) §483.20(f)(5) Resid (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a d agrees not to use of except to the exten to do so. §483.70(i) Medical §483.70(i)(1) In acc professional standa must maintain med that are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically of §483.70(i)(2) The fa all information cont	Identifiable Information b), 483.70(i)(1)-(5) Ident-identifiable information. crelease information that is to the public. release information that is to an agent only in contract under which the agent r disclose the information t the facility itself is permitted records. cordance with accepted irds and practices, the facility ical records on each resident mented; ble; and		341	Medical Director, responsibilities of the Medical Director to facility are being completed accurately and in accordance with contract and Administrator to ensur effective performance of responsibilities medical director until such a time that shows consistent substantial compliance with the regulations and until it has been determined by Administrator and COO that it is no longer needed. 5. The Administrator or designee will b responsible for this POC.	e of e	

Facility ID: 00995

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	records, except whe (i) To the individual, representative when (ii) Required by Law (iii) For treatment, p operations, as perm with 45 CFR 164.50 (iv) For public healt neglect, or domestic activities, judicial ar law enforcement pu purposes, research medical examiners, a serious threat to h by and in compliance §483.70(i)(3) The far record information a unauthorized use. §483.70(i)(4) Medice for- (i) The period of tim (ii) Five years from there is no requirem (iii) For a minor, 3 y legal age under Sta §483.70(i)(5) The m (i) Sufficient information (ii) A record of the m (iii) The comprehen provided; (iv) The results of a and resident review determinations com	en release is- or their resident re permitted by applicable law; <i>v</i> ; payment, or health care nitted by and in compliance 06; h activities, reporting of abuse, c violence, health oversight nd administrative proceedings, irposes, organ donation purposes, or to coroners, funeral directors, and to avert nealth or safety as permitted ce with 45 CFR 164.512. acility must safeguard medical against loss, destruction, or al records must be retained the required by State law; or the date of discharge when nent in State law; or ears after a resident reaches te law. nedical record must contain- ation to identify the resident; esident's assessments; sive plan of care and services ny preadmission screening revaluations and ducted by the State; se's, and other licensed	Fε	342			

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	י וסו	E CONSTRUCTION		0938-039	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245323	B. WING _			03/2	27/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 842	Continued From pa	ge 214	F 84	42				
	(vi) Laboratory, rad services reports as This REQUIREMEN by:	iology and other diagnostic required under §483.50. NT is not met as evidenced and document review, the			This Plan of Correction constitutes	mv		
1 (facility failed to ens complete and accu R2, R23, R6, R13,	ure clinical records were rate for 7 of 20 resident (R5, R21, R225) records reviewed. ial to affect all 23 residents			written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists of one was cited correctly. This Plan of Correction is submitted to meet	the ssion or that		
	Findings include:				requirements established by state a federal law.			
	R5's medical record wound care.	d did not accurately reflect			 It is the policy of the facility to e that the medical records are mainta medical records on each resident th 	ained		
	was observed to re from R5's sacrum. RN-D identified two the dressing. RN-E on the left buttocks second open area buttocks measured areas under the dre diameter were obse color and were not	5 p.m. registered nurse (RN)-D move a Duoderm dressing Upon removal of the dressing newly opened areas under measured the first open area to be 1 cm x 0.3 cm. The noted on the lower left 2 cm by 2 cm. The three essing approximately 1 inch in erved to be deep red/purple in blanchable. RN-D stated the			complete, accurately documented, accessible and systematically organ The facility failed to assure that clin records were accurate and complet R5, R6, R13, R21, R2, R23, R225. licensed nurses were retrained on 4 and 5/1/18 by DON and other facilit Nurse management on requiremen accurate medical record documenta and processes and Ad Hoc implement regarding this.	readily nized. ical te for All 4/25/18 y ts of ation ented		
	time she had obser areas were new an	d appearance since the last ved it. RN-D stated the open d the wound looked worse.			 All resident can be affected by the deficient practice. The policy on har reviewed and revised. To enhance currently compliant 	is been		
	documentation rela measurements fror				operations and under the direction of DON, on 5/1/2018 all nursing staff v receive in-service training on compl accurate, readily accessible and	will lete,		
	record and confirm completed any type	a.m. RN-E reviewed R5's ed the facility had not of documentation related to open areas identified on			systematically organized medical re requirements for all residents. Documentation will be reviewed and monitored by director of nursing to a	d		

Facility ID: 00995

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		AND HUMAN SERVICES			F	ORM A	05/04/201 PPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3		SURVEY LETED
		245323	B. WING			03/2	7/2018
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 842	had not completed regarding R5's wou stated she "spaced R5's Progress Note indicated R5 had a was yellow/green in surrounding the bru- not identify where to origin of the bruise. related to the bruise. related to the bruise. Review of R2's clin following informatic R2's Lift Mobility St indicated R2 did not weight on his/her let tolerate a semi-rect was to be transferred name of a full body the form was incom not been assessed sling nor did it ident memebers required An incident report of had sustained a sk while being transfer which required first not identify the root number of staff me	a.m. RN-D confirmed she any type of documentation inds treated on 3/21/18. RN-D it." e dated 3/13/18, at 11:20 p.m. 6 cm by 3 cm bruise which a color with some pinkness uise. The documentation did he bruise was located or the No further documentation e was noted in R5's record. ical record revealed the on: atus form dated 12/31/17, thave the ability to bear egs. R2 did have the ability lined position and indicated R2 ed with a MaxiMove (brand mechanical lift). The rest of applete, as it was blank. R2 had to identify the appropriate size tify the number of staff	F 8	42	the policies are being enforced. 4. Effective 4/24/2018, a quality-assurance program was implemented under the supervision of DON to monitor resident for accurate complete documentation, assuring electronic documentation and proper organization of information is followed The DON or designee will perform the following systematic audits on residen 50 % of residents per week x 4 weeks then 25% of residents weekly x2 moni- to ensure compliance in this area. Any- deficiencies will be corrected on the sp and the findings of the quality-assurance committee meeting for further review of corrective action. 5. The DON will be responsible for the POC.	and I. e hts; s, ths y pot, nce nitted or	
	An incident report of	lated 10/29/17, indicated R2					

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245323	B. WING _			03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	had sustained a ski hand while being tra- mechanical lift. The identify the root cau staff members pres- interventions to mir An incident report of had sustained a ski hand while being tra- mechanical lift. The identify the root cau staff members pres- to minimize further Further review of R documentation rela On 3/22/18, at 11:5 clinical services (RI not have any furthe R2's injuries and th present at the time On 3/27/18, at 10:0 stated she had ider documentation in th attempting to train a improve documenta stated the facility we plan to ensure com documentation. R23's Care Plan da was to utilize a plate R23 was able to ea of the meal.	in tear on the back of the right ansferred via a full body e documentation did not use of the injury, the number of set at the time of the injury or nimize further injuries. dated 11/15/17, indicated R2 in tear and bruise on her left ansferred via a full body e documentation did not use of the injury, the number of sent at the time or interventions injuries. 2's clinical record lacked ted to the identified injuries. 0 a.m. the regional director of DCS) confirmed the facility did e number of staff members of the injuries was unknown. 5 a.m. the administrator ntified a concern with he facility and had been staff members on how to ation. The administrator ould be developing an action	F 84	12			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	200	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	equipped with a pla On 3/20/18, at 12:0 be served the noon equipped with a pla On 3/20/18, at 5:05 evening meal. R23' a plate guard. On 3/21/18, at 12:1 noon meal. R23's p have a plate guard. - At 12:29 p.m. the any type of adaptive was identified on th Review of R23's die type of adaptive equipad an order for a p was discontinued a at the time, R23 wa himself. The DM sta documented the dis guard. Review of R23's clin documentation relat the plate guard. On 3/21/18, at 1:45 was unaware of the R23 was to be utiliz	 meal. R23's plate was not te guard. 5 p.m. R23 was observed to meal. R23's plate was not te guard p.m. R23 was served the s plate was not equipped with 5 p.m. R23 was served the olate was not observed to dietary manager (DM) stated e equipment required at meals e resident dietary card. etary card did not identify any uipment. The DM stated R23 olate guard in the past, but it bout six weeks ago because is not attempting to feed ated the nurses should have scontinuation of the plate nical record lacked ted to the discontinuation of p.m. the DON stated she a type of adaptive equipment for further 	F 8	342	DEFICIENCY)		
	documentation had	to her knowledge, no been completed. No further ovided regarding R23's plate					

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		AND HUMAN SERVICES				FORM	APPROVED		
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		LE CONSTRUCTION		0938-0391 E SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED		
		245323	B. WING			03/2	27/2018		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE		
IAG			IAG		DEFICIENCY)				
			1						
F 842	Continued From pa	ge 218	F 8	42					
	guard.								
	D6's alinical record	lacked documentation related							
	to the pacemaker n								
		<u> </u>							
		ed 6/28/17, identified R6 as							
		er due to atrial fibrillation. The rect the staff to assist to							
		aker via telephonic monitoring.							
	to the pacemaker n	lacked documentation related							
		lonitoring.							
		sed practical nurse (LPN)-B							
		a pacemaker and stated the nic monitoring were to be							
		ursing staff. LPN-A stated the							
		ere to be identified on the							
		on administration records							
	· ,	viewed R6's EMAR and stated							
		nclude pacemaker monitoring.							
	- At 1:17 p.m. LPN-	B entered the medication							
		pacemaker telephonic							
		LPN-B confirmed she had no 6 utilized the machine.							
		0 a.m. RN-E confirmed R6's							
		ed documentation related to							
	the pacemaker eva	iualions.							
	On 3/27/18, at 9:25	a.m. LPN-A stated the							
	pacemaker monitor	ing was scheduled in the							
		t book at the desk. LPN-A							
		ad a pacemaker check on							
		ated she had not completed ck. LPN-A stated that upon							
		acemaker monitoring, the							
		the staff as to when the next							

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING_			03/:	27/2018
NAME OF F	PROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			99 BIRCHWOOD AVENUE WEST PO BOX 7 ALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842		-	F 84	42			
	calendar, LPN-A sta	ake place. Upon review of the ated R6 did not have a ker check in the next six					
	the pacemaker che 2018, however, shi monitoring in the m During interview on stated R21 used to currently lived a cou- he could not get alo would threaten to "t being just two days months ago, when with staff present, F punched him in the being injured. R13 s witnessed the incide	D stated she had completed eck via telephone in February e had not documented the redical record. a 3/19/18, at 9:24 a.m. R13 be his roommate and uple doors from him, however, ong with R21. R13 stated R21 beat him up" most recently ago. R13 stated about two he was by the nursing station R21 had "rolled up and e left shoulder." R13 denied stated the staff who had ent told R21 he had to "settle being afraid of R21 and stated					
	stay away from R2 ² On 3/20/18, at 1:10 stated R21 and R13 did not get along ar so they got separat currently, when R13 room, R21 would ca witnessed the afore between R13 and F R21's clinical record resident to resident						
	management incide R225 had eloped fr	e facility's computerized risk ent list, an incident whereby rom the facility was noted and rned R225 to the facility,					

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION		0938-039 E SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		СОМ	PLETED	
		245323	B. WING			03/2	27/2018	
NAME OF F	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484			OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 842	Continued From pa	age 220	F 8	42				
	842 Continued From page 220 unharmed. On 3/20/18, at 6:30 p.m. Cook (C)-A stated R225 was not happy about being at the facilty and had eloped from the facilty a couple of times. C-A stated the incident with the police department was not the only time R225 had gotten away or attempted to leave the facility. C-A recalled another incident which occurred "way" before the police department incident, where he was going to go pick up R225 after he had left the facility and was downtown at a gas station which was across from the police department. C-A stated "somebody" had called the facility and informed the staff that one of their residents was there, however, that "somebody" had given R225 a ride back to the facility before he could go get him. C-A stated R225 used a wheelchair and would have had to get downtown by wheeling himself down the middle of the street as that was the only area of the road that had been plowed open following the snow fall. C-A remembered R225 being appropriately dressed for the cold winter temperature. R225's clinical record lacked evidence of this elopement and frequent, daily attempts to elope.							
	On 3/20/18, at 1:49 p.m. the administrator and the DON and the regional director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred and was not noted in the clinical records. At 4:25 p.m. the RDCS, administrator and the DON confirmed R225 had eloped from the facility on one occasion, however was not aware of the previous elopement which occurred prior to employment at the facility.							
	Region Medical Re	cords Safeguarding policy and 2/23/17, did not address the						

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		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY IPLETED	
		245323	B. WING _		03/	27/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO I WALKER, MN 56484	3OX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 842	Continued From pa	ge 221	F 84	2			
	required contents o	f a resident's medical record.					
F 867	QAPI/QAA Improve		F 86	7		5/6/18	
SS=F	CFR(s): 483.75(g)(2	2)(ii)					
	§483.75(g) Quality	assessment and assurance.					
	assurance committe						
	action to correct ide	plement appropriate plans of entified quality deficiencies;					
		NT is not met as evidenced					
	by: Based on interview	and document review, the		This Plan of Correction consti	tutos my		
		Performance Improvement		written allegation of compliance			
		ailed to identify and develop		deficiencies cited. However, s			
		to multiple system failures		of this Plan of Correction is no			
		as of elopement, falls, safe		admission that a deficiency ex			
		esident, staffing and staff		one was cited correctly. This			
		ction control, range of motion		Correction is submitted to mee			
		ulcers, social services, abuse		requirements established by s federal law.	late and		
		to ensure quality care. This affect all 23 residents residing		1. It is the policy of the facility	to ensure		
	at the facility.			that the Quality Assurance Per			
	Findings include:			Improvement committee ident develops appropriate action pl	ans related		
	On 2/27/10 -+ 0.04	a m the administrator and		to system failures. The facility			
		a.m. the administrator and DON) were interviewed about		have appropriate action plans system failures including elope			
		QAPI program activities. The		safe use of mechanical lift for			
		I she had started at the facility		sufficient staffing and competer	,		
	on 1/17/18, which h	ad been previous executive		infection control, range of mot			
		day. The administrator stated		pressure ulcers, social service			
		ne facility's QAPI minutes and		abuse prohibition to ensure qu			
	identified they had I			care. QAPI met on 2/20/18 wi			
	identification of syst	or action plans, and the		identified by Administrator that system was not reviewing ope	•		
		emented the newly developed		identifying OFIs, prioritizing OF			
	phase II nursing ho			determining the root cause an			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245323	B. WING _		03/	27/2018
NAME OF	PROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO B WALKER, MN 56484	DX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 867	Continued From pa	ige 222	F 86	57		
	implemented 11/27 completion of a fac administrator stated of systems, she hat the facility's corpora train the new direct fixing the system pu- her requests were of had identified system documentation, rep completion, however on staffing, recruitin identifying root cau order to develop an plans for compliand The administrator s committee met mod conducted was on a committee member gather specific qua statistical information Point Right comput the facility's quality incorrect and not up all of the facility man how to revise the in valid. The administ not reflected where or a the quality indicator identified. Administ rexplain to the mem the expectations of it was collected, an	 /18, which included the ility assessment. The d upon identification of the lack d requested assistance from ate office in order to help to or of nursing and assist with roblems identified however, denied. The DON stated she m issues related to orting, and fall incident er, her primary focus had been nent, scheduling, and se of system breakdowns in ad implement specific action ce. stated the quality assurance nthly and the first one she 2/20/18. She stated the facility's er based tool used to gather indicator information was p to date and had to educate nagers on how access it and aformation so statistics were rator explained the tool had facility statistics and there had n QAPI minutes which had how Point Right statistics of rs had been assessed or rator indicated she had to bers of the QAPI committee data collection including how alysis of the data collected, plan completion areas, and 		 implementing PIPs. In discussion Medical Director and QAPI mereod was determined and reviewed thad previously been ineffective. Administrator educated everyor QAPI program, the guidelines, and how to analyze data, etc. the effectively address systemic failing improve quality at facility. 2. Lack of appropriate action a system failures can affect all ree the facility. After identifying system failures from survey, ad hocs widentified and implemented, and to following scheduled QAPI on 4/17/2018. At this meeting, opp for improvement were identified prioritized, root cause was detered and performance improvement were initiated, reviewed and cobe monitored. 3. To enhance currently comp operations and under the direct Administrator, education was p Administrator to the quality assisted committee on 2/20/2018 when determined that previous meeti ineffectively being conducted. reviewed the elements and goa QAPI program, assistance and accurate data review, and propidentification of root cause while goals are SMART (specific, me attainable, realistic and time ori On 5/1/2018 all staff will received training regarding QAPI program on the committee and their role discussed, frequency of meeting report suggestions to bring to Committee on the program on the committee and their role discussed frequency of meeting report suggestions to bring to Committee and their role discussed. 	hbers, it hat QAPI he on the processes begin to ures to blans for sidents at em ere d brought ortunities , mined, plans ntinue to liant ion of the ovided by urance t was ngs were Education ls of the tools for er assuring asurable, ented). e in-service n, who is s, what is gs, who to	

Facility ID: 00995

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		(X1) PROVIDER/SUPPLIER/CLIA	. ,	PLE CONSTRUCTION		E SURVEY
NU PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
		245323	B. WING		03/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 867	Continued From pa	ge 223	F 86	57		
	 Continued From page 223 QAPI committee action plans were reviewed from 9/2017 through 2/2018. QAPI plans dated 2/5/18, included the following opportunities for improvement: implement phase II requirements, general compliance concerns, nursing department not at level where they need to be operating, facility assessment, abuse prevention program, reporting abuse neglect, clinical protocols, and decision tree. The areas identified had an action plan and notes indicated they would be reviewed at the next QAPI meeting and plan to identify more specific opportunities for focus. The QAPI committee log dated 2/20/18, indicated presentation of plans dated 2/5/18, and identified a concern with the way QAPI data had been gathered. The notes included, medical director and team stated the information in the past meetings didn't contain quality information and 			 where monthly posting of review of months QAPI are, etc. 4. The QA committee will meet re to discuss action plans related to deficiencies noted during survey, and analyze audits and determine appropriate continued monitoring system changes in addition to oth already identified on the QAPI pla agenda. The medical director will present monthly and pharmacy co will be present at a minimum quar not present minutes will have sub them prior to meeting to allow for during meeting, then will be review signed monthly. Audits are in plan reviewed monthly to assure that a supporting documentation from ea department head is submitted to the Administrator the Monday prior to for adequate time to review. After the minutes and supporting 	nonthly review or er items n be onsultant terly; if mitted to input ved and ce and II ach he meeting QAPI	
	not reoccur and mo identified. The forms used for through 1/16/18, we to the previous corp ongoing quality ass maintain compliance deficient practice. T identification of spe required performan compliance. QAPI of root cause analy and identification of	cific measures for sure the deficient practice did onitoring system were QAPI logs from 9/1/17 ere printed on forms belonging borate owner. The logs lacked urance activities in order to be with identified areas of The logs further lacked ocific areas/systems that ce improvement for logs further lacked evidence sis with supporting evidence, f comprehensive action plans fic goals and time frames for		 documentation will then be sent to and COO for review. This plan of correction will be monitored at the QAPI meeting and audits to contin such a time that shows consistent substantial compliance with the regulations and the facilities QA has been met, as determined by a representative of the regional exe team. 5. The Administrator or designed responsible for this POC. 	monthly nue until PI plan a cutive	

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA). 0938-039 TE SURVEY MPLETED
				IG		
		245323	B. WING _		03	8/27/2018
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ILD BE	(X5) COMPLETIO DATE
F 867	lacked evidence ac analyzed and revise successful complet monitoring systems areas in need of im reported areas wer month with no char QAPI committee lo -Elopement identifie guard alerts needed maintenance monit system. There was analysis of staff res action plan to impro- -Falls number of fa definitively be deter report was complet which occurred all minimally identified lights or asking for "working on getting an analysis of what residents related to evening shift and la interventions until n addition there was plan. -Mechanical Lift- ne members" -Infection control id infections from hos prevent the spread maintain compliance	d completion. The logs also ction plans were implemented, ed as necessary to ensure tion. The logs had no is to assist in ascertaining provement. The logs identified e carried over from month to nge. gs for 9/19/17 included: ed staff response to wander d improvement and cored the wonder guard no evidence of root cause sponse time or evidence of an	F 86			

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		245323	B. WING			03/	27/2018	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
WALKER	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 867	pressure ulcers. The indicated that most resident admission root cause analysis reoccurring, no evid improve, or prevent there was no indicate been developed an -Nurse competency waiting for forms from QAPI committee lo -Elopement continue previous month. -Infection control re- previous month. -Infection control re- previous month. -Infection control re- previous month. -Infection activities -Mechanical lift idea during a lift transfer scared and grabbin further review. -Falls PIP for person personal alarms we the exception of on identified "get all al- indicated eight falls previous month, wi using call light, not under-staffed durin action plan discuss -Pressure ulcers wit identified as, "Most G-tubes (gastrointer feeding/medication /sores/surgical wou	ing identification of reoccurring ing identification of reoccurring he root cause analysis only wounds were present upon . There was no evidence of of ulcers that were dence of an action plan to t worsening. Furthermore ation monitoring systems had d implemented. / status none completed om corporate. gs dated 10/17/17, included: ued to repeat information in emained unchanged from though the influenza season there were no influenza s identified. ntified an injury to one resident related to resident getting g onto the bars. There was no onal alarms indicated all ere removed on 10/6/17, with e resident. The plan only arms removed". Fall tracking , twice as many as the th reasons that included not asking for assistance, and g the evening shift. No further	F	367				

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245323	B. WING	i		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 3 WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	on buttocks". The p plan and there was system was develop -Nurse competency month. QAPI committee log -Elopement same a -Infection control sa No influenza prever -Mechanical lift inju (same resident from incidents that result arms from grabbing plan lacked a root of actions taken, or a -Falls report indicat was doubled from t action plan discuss -Nurse competency progress, and forms corporate. -Pressure ulcers the in pressure areas a working with corpor QAPI committee log -Elopement continu staff response time -Infection control id and type. No furthe Indicated hand was completed. -Mechanical lifts for same resident was unchanged. -Falls indicated the during the month; 3	olan further lacked an action no evidence a monitoring ped and/or implemented. y status same as previous gs 11/21/17, included: as previous two months. ame as previous two months. ntion activities were identified. ries identified one resident n previous month) with two ted in skin tears on hands and g onto the bars. The action cause analysis, evidence of plan to monitor for efficacy. red a total of 16 falls, which he previous month. No further	F	367			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		045000	B. WING				
		245323	B. WING _		03	/27/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BC WALKER, MN 56484	X 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 867	pressure ulcers, ho action plan was the months. -Staffing This first r "increasing staff wh plan did not identify current needs were evidence of how the determined. There assessment develor ratios. -Nurse competency progress. No furthe QAPI committee lo - Elopement of a re- station. The root ca confusion and staff guard alarm. Staff s guard system had l since September. Ta analysis or planning -Infection control in bronchitis/respirato identified "influenza Department of Hea Assessment and R scheduled visit had Influenza A. The re- patterns/trends of in prevention measure	vailable. dentified an increase in ovever all information including e same as the two previous month PIP identified hile increasing census". The y minimum staffing levels or if e being met. There was no e planned staffing ratios were had not been a facility oped which included staffing y status identified to be in er information provided. gs dated 1/16/18, included: esident who went to the police ause was identified as resident i response was slow to wander slow response to wander been identified every month The plan lacked any further g.	F 86	57			

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245323	B. WING			03/2	27/2018
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
pressure areas/weth and brief company f -Falls a performance for falls indicated th all personal safety a corporate goal. All of removed on 10/6/18 resident. The report progress to meet th related to nursing re- however, indicated on 1/11/18. The fall than a two fold increace however it is uncleane There was no evide been collected, root development/impler minimize the risk of -Nurse competency in progress. No othe -Staffing Second me same concerns with The plan did not ide did not identify servit analysis on impact of care/quality of life. If evaluate and develop care and services w available based on assessment had no QAPI Committee G included the QAPI of sustains living center clinical and non-clin self-identification ar	vere unchanged. "Due to ness working with corporate to remedy situation." be improvement project (PIP) e facility had a goal to remove alarms to align with the of the alarms had been 8, with the exception of one t further indicated the facilities be goal had been not obtained eplacing alarms on residents, the last alarm was removed report indicated a total more ease since September, ar if the data was accurate. ence of how the fall data had t cause analysis, or mentation of an action plan to falls. v indicated competencies were er information was recorded. onth of PIP and indicated n staffing and resident census. entify minimum staffing levels, ices that were impacted, or an of resident quality of n addition, the facility did not op a plan for the provision of when enough staff was not the outlined goal. A facility	F	367			

Facility ID: 00995

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY	
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:	· ,	B		IPLETED	
		245323	B. WING		03	/27/2018	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
WALKEF	REHABILITATION &	HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484			. 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 867	Continued From pa	ige 229	F 867	,			
F 880 SS=L	projects (PIPs) to e services identified i System chart inclue identify OFI's throu observation, prioriti causes using fish b steps, implement P development, learn outcome. QAPI PIP LOG: col improve care or se identified as needin concentrated effort area of the facility of gathering informati- issues or problems improvements. PIP important and mea and scope of servio The guidelines dire measures (QM)'s a summarize and an trends, determining opportunities, and n guidelines then dire plan based on colle	ded; Review of operations, gh data review, trends zation of OFI's, determine root oone, 5 whys, and process PIP smart goals, approach, ing, integration (ADLI), sustain nduct PIPs to examine and rvices in areas that are ag attention. A PIP is a on a particular problem in one or facility wide; it involve on systemically to clarify , and intervening for 's are selected in areas ningful for the specific type ces unique to the facility. cted to review quality and directed on how to alyze data including reviewing g root cause, identify education need for education. The ected to determine an action ected data. n & Control	F 880			5/6/18	
	infection prevention designed to provide comfortable environ	stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable					

Facility ID: 00995

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		AND HUMAN SERVICES					FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245323	B. WING	i			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST P WALKER, MN 56484	O BOX 7	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 880	program. The facility must est and control program a minimum, the follo §483.80(a)(1) A system reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited to (i) A system of surve possible communicable dise reported; (iii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pre- (iv)When and how i resident; including b (A) The type and du depending upon the involved, and (B) A requirement th least restrictive pos- circumstances. (v) The circumstance	n prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment og to §483.70(e) and following tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; solation should be used for a out not limited to: uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility	F	380				
		oyees with a communicable skin lesions from direct						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMI	PLETED
		245323	B. WING		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	. 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 880	Continued From pa	age 231	F 88	0		
	contact will transmi (vi)The hand hygier	nts or their food, if direct it the disease; and ne procedures to be followed direct resident contact.				
ic	identified under the	stem for recording incidents facility's IPCP and the aken by the facility.				
	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread infection.	ndle, store, process, and				
	IPCP and update the This REQUIREMENT	duct an annual review of its neir program, as necessary.				
	This REQUIREMENT is not met as evider by: Based on observation, interview and docu review, the facility failed to develop and ma an ongoing infection control surveillance pi to identify potential infectious outbreaks. T failure resulted in an immediate jeopardy (to an influenza A outbreak from 1/5/2018 - 1/18/2018, in which droplet precautions we	ailed to develop and maintain in control surveillance program infectious outbreaks. This in immediate jeopardy (IJ) due utbreak from 1/5/2018 - in droplet precautions were not		1. The goal of the facility is to pr safe, sanitary, and comfortable environment and to help prevent t development and transmission of During the survey, it was noted 5 residents were confirmed to have influenza, 3 received treatment HS	he disease. S, MY,	
	R6) who tested pos additional residents R227, and R2) who symptoms of influe procedures related been developed an	ents (R12, R124, R125, and sitive for influenza A, and for 8 s (R21, R10, R9, R4, R1, R8, o displayed signs and nza. In addition, policies and to infection control had not ind implemented. This practice o affect all 23 residents residing		CS. HG refused treatment, and ur why 5th E.S. did not receive treatr was then noted per infection contr that 8 other residents showed sign symptoms of influenza but were n confirmed. No documentation as t they were not tested to confirm dia Carts were not supplied in halls, s	nent. It ol log ns and ot o why agnosis.	
	in the facility at the addition, the facility precautions were in R24) who were infe	time of the outbreak. In railed to ensure contact nitiated for 2 of 2 residents (R5, ected with organisms which ecautions. Additionally, the		was not on individual doors and in interviewing staff they were unsur- where to find PPE and what differ of precautions there were. Staff interviewed by regional director or	e of ent type	

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		& MEDICAID SERVICES	()(0)				<u>)938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X:		SURVEY LETED
		245323	B. WING			03/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NALKEF	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIO DATE
F 880	Continued From pa	ge 232	F 8	80			
	facility failed to ensure was completed for a R2) observed to rec practice had the por residing at the facilit Findings include: The IJ related to inf the lack of initiation on 1/5/18, when R1 influenza A and the standard and droplet transmission of influ Three additional res tested positive for in developed flu like s highly contagious d through air droplets director of nursing (3/23/18, at 4:05 p.m removed on 3/27/18 non-compliance rer level of F, which ino failure which had th residents residing in According to the Ce (CDC) an outbreak care facility is identit testing positive for i influenza are encou- others and standard to be initiated. (refe people who get influ days to less than two	ure appropriate hand hygiene 3 of 8 residents (R8, R18 and ceive medications. This tential to affect all 23 residents ty. Fection control practices and of isolation precautions began 2 was diagnosed with facility failed to initiate et precautions to prevent the uenza to other residents. sidents (R125, R124 and R6) influenza and 8 other residents ymptoms. Influenza A is a isease which is spread 5. The administrator and the (DON) were notified on in. of the IJ. The IJ was 8, at 12:00 p.m., however, mained at a scope and severity dicated a widespread systemic ie potential to affect all in the facility. enters for Disease Control of influenza in a long term ified as two or more residents influenza. Individuals with uraged not to mingle with d and droplet precautions are erence: www.CDC.gov). Most uenza will recover in a few yo weeks, but some people will ons (such as pneumonia) as a	ΓO		 (2 nurses and one aide) that all resider that had symptoms did stay in their rowhile not feeling well, staff had access masks and if residents did come out twore them as well, but only residents without symptoms could go to dining room. Signs were up for notification at sanitizer and masks were available at entrance. In another situation, a resider TL was diagnosed with MRSA in his g-tube site and no precautions were in place to prevent transmission. The fact failed to initiate, monitor and impleme an infection control program. Basic infection control program failed to prevent transmission. The fact further cross contamination from resider and staff. The facility was not adequate ducated on standard, contact and draprecautions nor where adequate signs available to ensure staff knew who way isolation or where isolation carts were located. No negative outcome was identified to be caused by the alleged deficient practice. 2. Corrective action taken for thos residents having the potential to be affected by the alleged deficient practice. 2. Corrective action taken for thos residents having the potential to be affected by the alleged deficient practice. 2. Corrective action taken for thos residents having the potential to be affected by the alleged deficient practice. 2. Corrective action taken for thos residents having the potential to be affected by the alleged deficient practice. 3. Corrective action taken for thos precautions have been reviewed and identified and the procedure for putting those precautions has been put into place. Residents receiving antibiotics currently have had their orders review to ensure no cross-contaminating pathogens or viruses have gone unnoticed. The director of nursing alow with pharmacy consultant have review. 	oom s to they and t lent n cility ent dents ately roplet s as on e se tice: on g ved	

Facility ID: 00995

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI		B NO. ((3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245323	B. WING			03/2	7/2018
IAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 700 VALKER, MN 56484)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 880	Continued From pa	ge 233	F 8	380			
	of complications from chronic health prob On 3/23/18, at 8:00 clinical services (RI have a nurse identified infection control pre- all infection control pre- all infection control were to be directed - At 8:30 a.m. the and were interviewed re- practices of the fac assumed the respondance of the	d ear infections are examples of flu. The flu can make lems worse. a.m. the regional director of DCS) stated the facility did not fied to act as the facility's eventionist. The RDCS stated surveillance and concerns to the director of nursing. dministrator and the DON egarding the infection control lity. The DON stated she had nsibilities of the DON in the only infection control log ate was for an influenza / 2018, which had been ormer DON. The DON stated the infection control e week of 3/12/18, for the February and March 2018, ed resident records and re residents who had been tics. The DON confirmed the the tracking or trending of e not treated with antibiotics.			spread of infection, appropriate infect control practices will be implemented including isolation, the use of standar precautions, and utilization of persona protective equipment. 3. Measures/Systemic changes p place to assure the alleged deficient practice does not re occur: All staff w immediately educated regarding findii to include infection prevention progra which were put into effect immediatel staff (nursing, housekeeping and leadership team) in building 3/24 and have been educated on where isolatic carts are (more have been ordered), the different precautions are and whe ensure isolation precautions are put in place to reduce further transmission. staff will be educated on their next sh prior to working. Ensuring staff also understand indirect vs. direct transmission. Infection Control Program will be led the director of nursing and discussed quarterly at QAPI the program goals a to: 1. Investigate, control, and prevent infections in the facility;	I, rd al put in vere ings im I 3/25 on what en to in All hift by I	
	on 1/5/18, indicated Influenza A on 1/5/1 additional residents also tested positive 1/5/18 and 1/15/18. were identified as d (including but not lin	Ilness Line List form initiated I R12 had tested positive for 8. The form identified three (R125, R124, and R6) who for Influenza A between Eight additional residents isplaying flu like symptoms mited to fever, cough, muscle chills) during the identified			 Decides what procedures, such as isolation should be applied to an indiv resident according to pathogen determined; Maintain a record of incidents (outbreaks or trends) and corrective actions related to infections. All residents determined to need isolat will be monitored and isolation precautions utilized immediately. 	vidual	

Facility ID: 00995

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		& MEDICAID SERVICES	1		OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245323	B. WING		03/2	27/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WE WALKER, MN 56484	ST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 880	Continued From pa	ge 234	F 88	0			
	According to the fac the Minnesota Depa dated 9/21/16, influ predominately by la are expelled from th coughing or sneezin usually did not rema close contact (usua required for transm 24 hours prior to the were usually contag onset of illness. Th influenza was ident website directed the outbreak by the imp droplet precautions suspected or confir precautions were to days after illness or resolution of fever a whichever was long Examples of Standa identified as: - wear gloves - wear gloves and encounter	cility information printed off of artment of Health website enza transmission occurred irge respiratory droplets that he respiratory tract during hg. The droplet particles ain suspended in the air, and illy less then three feet) was ission. Infectiousness begins e onset of the illness. Adults gious until five days after the he facility to control an influenza obementation of standard and for all residents with med influenza. The o remain in place for seven hest or until 24 hours after the and respiratory symptoms, ger. ard Precautions were	F 00	 to ensure the alleged denot re occur: Infection Control Predirector of nursing or deall orders taken daily to residents needing isolat This will be done daily for then reviewed by QAPI further monitoring needer Preventing Spread or easy to disinfect carts h supplies to pre-stock as have been put together. be inventoried and stock shift as new nightly procearts are ready and ava Education – Staff wittin immediately to infection and educated on where located, new resource be station, education will be packet, infection control at annual in-service. Infeaudits will be completed nursing or designee on randomly selected but the employees are reviewed over next 3 months and next 3 months, so every reviewed during that time results will be discussed determine if further mor These audits will ask station 	ogram – The signee will review monitor for ion precautions. or one month, and to determine if ed. of Infection – New ave been ordered, well as signage These carts will ked every night sess to ensure ilable at any time. ill be in-serviced control practices supplies are inder at nursing e put into new hire will be reviewed ection control by director of employees o ensure all d once a week then randomly for v employee will be e frame and then d at QAPI to itoring needed.		
	as: - private rooms if po - cohorting ill reside unavailable	et Precautions were identified ossible ents if private rooms were upon entering the resident		located, can staff identif type of precaution, when plan located and indirec contamination. Completed 3/25/2018 Further review since sur	y each different e is the infection t vs indirect		

Facility ID: 00995

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 9 BIRCHWOOD AVENUE WEST PO BOX 7	~~	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		00			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 880	Continued From pa	age 235	F 88	30			
	 Continued From page 235 room have the resident wear a facemask if movement or transportation is necessary. The Superior Healthcare Management Minnesota Region Influenza, Prevention and Control of Seasonal (influenza) policy dated 12/27/17, directed the staff to initiate standard and droplet precautions for all residents identified with influenza. R12's quarterly Minimum Data Set dated 1/26/18, indicated R12 had intact cognition, required limited to supervision/set up for activities of daily living, did not walk, and was independent with locomotion on and off the unit. The MDS also indicated R13 was offered but declined the influenza seasonal vaccine. 				admitted with pathogen which need isolation have been reviewed. Infect control measures in place, pre-set of carts ready with signage and no fur residents have been identified. One resident did present with MRSA and proper procedure was followed. Handwashing audits done on all sta during first week. Then 4 staff per w x2 weeks and 2 staff per week x2 m Facility remains in compliance.	tion up ther d d aff veek	
	R12's Doctor's Order Sheet indicated on 1/8/18, R12 had been sent to the emergency room on 1/5/18, due to an increased temperature, cough, yellow mucous, and lethargy. R12 was diagnosed with influenza A and treated with Tamiflu (an anti-viral medication to treat influenza). Although R12's clinical record reflects staff had instructed R12 to remain in his room during his illness, there is no evidence droplet precautions had been implemented.						
	severely impaired of assistance of one to daily living, and had	MDS indicated R124 had cognition, required extensive to two staff for all activities of d received the influenza mission to the facility.					
	indicated at 7:20 a	lote (PN) dated 1/7/18, .m. R124 had a low grade productive cough with wheezing					

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION	MB NO. (X3) DAT	E SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	i	COM	IPLETED	
		245323	B. WING	VING			27/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
WALKEF	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 880	Continued From pa	age 236	F 8	880				
		ted with Tylenol. At 11:20 a.m.						
		g was noted, however, R124						
		ighing up yellow phlegm. R124 er than she had the night						
		, at 2:10 a.m. indicated R124						
		w grade temperature,						
		on productive cough. R124 had						
	remained in her roo spread of infection.	om in order to prevent the						
	•	, at 10:51 p.m. indicated R124						
		estless and her skin was warm						
		.6, has loose productive						
		/heezing, and oxygen 0%. R124 was sent to the						
	emergency room fo							
	-A PN dated 1/8/18	, at 2:52 a.m. indicated R124						
		e hospital for treatment of						
	influenza A and pne	eumonia. inical record reflected isolation						
	0	cord lacked evidence of the						
	implementation of o							
		MDS dated 1/9/18, indicated						
		e cognitive impairment and l assistance from one staff						
		ties of daily living. The MDS						
		5 was offered but declined the						
	influenza seasonal	vaccination.						
		/11/18, indicated the resident						
		sent to the emergency room.						
		indicated R125 was ner hospital for neurological						
		8, indicated R125 remained in						
	the hospital and wa	as diagnosed with and treated						
	for influenza.	9 indicated D125 returned to						
		8, indicated R125 returned to						

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	and urinary tract inf and assistance of o living. -A PN dated 1/18/13 attempted self trans the staff member as down to the nurse's located in the main visitor traffic flow. -A PN dated 1/18/13 continued to have a would be getting up -A PN dated 1/19/13 had expired. -R125's clinical record molementation of in R6's clinical record Notification dated 1 facility had been no for influenza A. R6 and an antibiotic for Review of R6's prog 1/17/18, revealed fr remained in her roc was noted to have a Fahrenheit, an occ voice. On 1/15/18, dining room for mea her her room as sho Further review of th January 2018, reve who had displayed sym	proses including influenza A, fection, required oxygen use one staff of all activities of daily 8, indicated R125 had sfers several times, therefore ssisted R125 up and took her a station which was directly a corridor of resident and 8, at 3:35 p.m. indicated R125 adventitious lung sounds and o for supper. 8, at 2:58 a.m. indicated R125 ord lacked evidence of the nfection control precautions. contained a Status Change /8/18, which indicated the otified R6 had tested positive received an order for Tamiflu r the treatment of pneumonia. gress notes from 1/8/18 - rom 1/8/18 - 1/14/18, R6 om. However, on 1/14/18, R6 a temperature of 99.0 degrees casional cough, and raspy R6 ambulated to and from the als. On 1/16/18, R6 remained e was not feeling well. the Infection control log for caled eight additional residents symptoms of influenza.	F٤	380			
	included sore throa						

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
				NG.			
		245323	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER				09 BIRCHWOOD AVENUE WEST PO BOX 7	'00	
WALKER	REHABILITATION &	HEALTHCARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880		ige 238	F 88	80			
	congestion.						
	included vomiting, t headache. On 1/7 a non-productive cou	nptoms on 1/6/18, which temperature of 101.8, and and 1/8/18, symptoms included gh, productive cough with increased chest congestion.					
	included a tempera	ptoms on 1/10/18, which ture of 101.2 degrees along ore throat, cough and sinus					
	included a tempera	ptoms on 1/10/18, which ture of 101.1 degrees along ore throat, cough and sinus					
		otoms on 1/15/18, which ture of 100.5 degrees along ion					
	included temperatu	otoms on 1/15/18, which ire of 100.8 degrees along with chills, and sinus congestion.					
	included a tempera	mptoms on 1/15/18, which ture of 100.8 degrees along head ache, cough, chills, and					
		ptoms on 1/17/18, which hills and sinus congestions.					
	lacked indications t	f the infection control logs hat the aforementioned tion precautions initiated at the m onset.					

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF PROVIDER O	R SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABIL	ITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	00	
PREFIX (EACH	I DEFICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Review of improver dated 1/ ² bronchiti- identified Departm Assessm schedule influenza patterns/ prevention transmis infections departme analysis that hand complete address influenza the influenza the influenza the influenza utilized. -At 8:20 s utilizing i past six n - At 8:52 four resid and 9 ad symptom not imple	nent (QAF l6/18, iden s/respirato "influenza ent of Hea ent and R d visit had A. The re trends of i on measure sion based s had beer ent, or ong for the ide d washing ed. In addit any quality preparation of the facili , yet isolat a.m. NA-A nfection co months. a.m. the D dents who ditional res is. The DO emented di	age 239 ty assurance performance 1) committee meeting log tified infections of ry and cellulitis. Notes in house" and Minnesota 1th Infection Control esponse Program's (ICAR) to be rescheduled due to port did not identify outbreaks, influenza, infection control es taken such as initiation of a precautions (isolation), if the neported to the health oing monitoring systems. The ntified infections concluded competencies needed to be ion, the QAPI logs did not assurance activities for on that began on 10/1/17.	Fε	380			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 /ALKER, MN 56484	'00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	• • • • • • • • • • • • • • • • • • • •	-	F 8	80			
	stated the facility has six months. NA-F j	ate all PPE supplies. NA-C ad not utilized PPE in the past joined the conversation and ad the facility had not utilized months.					
	utilized PPE in the p and masks were ut	-B stated the facility had not past year. RN-B stated gloves ilized during the influenza staff, but at no time were					
	influenza outbreak printed a sign off of it on the front door. did not have any typ notify staff, resident had a potential con stated the facility ha had not seen them	IUC stated during the in 1/2018, the former DON if the CDC website and posted The HUC stated the facility pe of signs in the facility to t or visitors, when/if a resident tagious infection. The HUC ad signs in the past but she for many years. The HUC of recall the last time PPE was y.					
	a.m. RN-B stated i binders had been p all to review and sig	ing visit on 3/25/18, at 8:54 infection control education placed at the nurses station for gn off, however, she stated ne to review them yet.					
	had been provided	stated the only training she was related to the use of the ht lift and neck brace.					
	3/27/18, at 12:00 p. the following interve	on 1/5/18, was removed on .m. when the facility completed entions were verified through nterviews and record review:					

Facility ID: 00995

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/;	27/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	• · · · · · · · · · · · · · · · · · · ·	olicies and procedures were	F 8	80			
	- Additional persona was ordered for the	al protective equipment (PPE) a facility.					
	- All staff members PPE was located.	were educated on where the					
	- Infection control s use.	igns were ordered for future					
	control polices and	cated on the facility infection procedures, including when to n based precautions in order to of influenza.					
	Contact Precaution	s:					
	gastrostomy tube s discharge (color no documentation indie gastrostomy tube s started on an antibi Staph Aureus (MRS	21/17, indicated R5 had a ite which was pink and had it identified). The cated a culture of the ite was obtained and R5 was iotic for Methicillin Resistant SA) which is a type of staph stant to several antibiotics.					
	on 12/13/17, indicat	th laboratory results collected ted R5 had Methicillin coccus at the gastrostomy					
	daily "infection note was receiving an ar tube site infection w	22/17 - 12/30/17, included es." The notes indicated R5 ntibiotic for the gastrostomy vith drainage, however, the not indicate if isolation					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245323	B. WING			03/;	27/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 NALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	precautions had be An Infection Surveil dated 12/20/17, ind with MRSA and treat were to implement of R24 was admitted t diagnoses that inclu- infection following a fluid (CSF) leak, ge and headache. Review of the hosp 12/14/17, indicated for a CSF leak follo spinal incision was staphylococcus epic R24 was given IV a nursing home to red 12/21/17. Review of R24's me assessments and p stay in the facility (1 R24 had not been p precautions as iden infection control. The of Transmission Ba 12/23/17, revealed in contact precaution wound infected with and candida albicar During interview wit 11:04 a.m. she cont in R24's record con implemented as the	en initiated. Ilance Data Collection Form licated R5 had been identified ated with antibiotics. The staff contact isolation precautions. The staff contact isolation precautions. The facility on 12/15/17, with uded but were not limited to: a procedure, cerebrospinal meralized muscle weakness, ital dismissal summary dated R24 underwent a dural repair wing a lumbar fusion. The cultured and was infected with dermis and candida albicans. Intibiotics and sent to the ceive IV antibiotics until edical record including all progress notes for the entire 12/15/17 - 12/22/17), revealed blaced into isolation tified by the facility's policy for he policy Isolation- Categories used Precautions dated R24 should have been placed ons for the draining spinal n staphylococcus epidermis ns. th the DON on 3/23/18, at firmed there was no indication tact precautions were e infection control policy for	F 8	.80			
		e infection control policy for					

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		AND HUMAN SERVICES				FORM	APPROVED			
	COF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA		וחו	LE CONSTRUCTION		0938-0391 E SURVEY			
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED			
		245323	B. WING			03/2	27/2018			
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	EET ADDRESS, CITY, STATE, ZIP CODE				
WALKER	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)			
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE			
1/10		,			DEFICIENCY)					
F 880	Continued From pa	ge 243	F 8	80						
	The Superior Healt	hcare Management Minnesota								
	Region MRSA polic	y dated 12/27/17, directed the								
		contact precautions if resident								
	had draining fluids.									
		a.m. the DON confirmed R5								
		d and treated for MRSA, yet ecautions had not been								
	implemented.									
	- At 8.15 a m licens	sed practical nurse (LPN)-B								
		ot recall utilizing any type of								
	isolation precaution	is in the facility. LPN-B								
		been treated for MRSA in the								
		and the facility had an za, yet isolation precautions								
	had not been utilize									
	At 0.00 NA A									
		stated she could not recall ontrol isolation gowns in the								
		A-A stated she had utilized the								
		or residents who had tested								
	positive for MRSA o	or C-Diff.								
	- At 9:10 a.m. the a	dministrator stated the facility								
		ution supplies in the facility,								
		d have to ask the health unit								
	located.	where the supplies were								
		en the infection control								
	practices of the faci	ility had last been reviewed,								
		ated she had started at the								
		and had no records of when I policies and procedures had								
		he facility. The administrator								

		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245323	B. WING			03/:	27/2018
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WALKEF	R REHABILITATION &	HEALTHCARE CENTER			09 BIRCHWOOD AVENUE WEST PO BOX 7 VALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	 stated the corporate annually but she did the policy review. At 9:20 a.m. the a forward the staff we control practices an procedures, howeve the education at the progress. At 10:15 a.m. LPN required droplet or would have to find t protective equipme not state where the facility. LPN-B aske where the supplies LPN-B to the supply designees office. At 10:21 a.m. NA- and was able to loc stated the facility ha six months. NA-F j NA-F also confirme PPE in the past six At 10:42 a.m. RN- utilized PPE in the p and isolation carts of had something com 	e level policies were reviewed d not have access to proof of administrator stated going ere to be trained on infection nd how to implement the facility er, the staff had not received e time and it was a work in N-B stated that if resident isolation precautions, she the supplies for personal nt (PPE), however, she could PPE was located in the ed nursing assistant (NA)-C were located. NA-C directed y closet in the social service -C opened the supply closet cate all PPE supplies. NA-C ad not utilized PPE in the past joined the conversation and ed the facility had not utilized months. -B stated the facility had not past year. RN-B stated gowns were to be utilized if a resident tagious like MRSA. RN-B MRSA in the past four months	F 8	80			

		AND HUMAN SERVICES				FORM	: 05/04/2018 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DAT	E SURVEY IPLETED	
		245323	B. WING _			03	/27/2018
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
WALKE	R REHABILITATION &	HEALTHCARE CENTER			BIRCHWOOD AVENUE WEST PO BO ALKER, MN 56484	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 880	Superior Healthcard Meeting dated 11/3 "The Governing boar report, train and reipractices across all On 3/23/18, at 8:52 was unaware of any training that had be However, infection to be completed in A Medication administ On 3/20/18, at 7:19 preparing medication occasions, RN-C w bottle of medication open the bottle and bottle directly into h a soufflé cup. RN-C returned the bottle and bottle directly into h a soufflé cup of m assist R8 to take th - At 7:31 p.m. RN-C cart, he/she was no hands as he began R18. RN-C dispensi individualized bubb cup. He/she then c bottle directly into h the soufflé cup. RN-C	e Management Govern Board /17, indicated the following: ard has asked all locations to nforce infection control departments." e.a.m. the DON stated she y type of infection control een completed in the past year. control training was scheduled April 2018. etration: p.m. RN-C was observed on for R8. On three different ras observed to remove a ns from the medication cart, dispense one pill out of the iis/her hand before adding it to C then recapped the bottle and to the cart. RN-C then carried nedications into R8's room and	F 88	80			

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		AND HUMAN SERVICES				FORM	05/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245323	B. WING			03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WEST PO BOX 7 WALKER, MN 56484	00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	discontinued at whi calcium tablet from it out with his/her fir medication in the tra the medications to b - At 8:27 p.m. RN-C cart and began dish RN-C was not obse prior to opening a b and placing two tab into his hand and at RN-C added three at (carbidopa-levadop furmaratate) to the bubble cards. RN-C medications and ad - At 8:38 p.m. RN-C all medications from prior to adding then cups. RN-C stated medications from th The undated Admin directed the staff to control procedures medications as app On 3/26/18, at 11:3 confirmed medication the staff were to di the bottle into the car	n had recently been ch time he/she removed the the medication cup by picking ngers and discarding the ash. RN-C then administered R18. C returned to the medication ning medications for R2. erved to wash his/her hand bottle of Tylenol 325 milligrams lets directly from the bottle dding them to a soufflé cup. addition medications a, remeron and quetipine soufflé cup from individualized C then crushed all of the Iministered them to R2. C confirmed he had dispensed in the bottles into his/her hand in into the resident soufflé he/she normally dished the he bottles into his hands. Anistering Medication policy, follow established infection during the administrator ons were not to be dispensed e into the staff members hand. spense the medication bottle, or	F 8	380			
F 943 SS=E		d Exploitation Training	F۶	943	6		5/6/18

Facility ID: 00995

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		AND HUMAN SERVICES			PRINTED: 05/04/2018 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245323	B. WING_		03/27/2018
NAME OF PROVIDER OR SUPPLIER WALKER REHABILITATION & HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 209 BIRCHWOOD AVENUE WEST PO WALKER, MN 56484	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 943	Continued From pa	ge 247	F 94	43	
	In addition to the free and exploitation red facilities must also that at a minimum of §483.95(c)(1) Activ neglect, exploitation resident property as §483.95(c)(2) Proce of abuse, neglect, e misappropriation of §483.95(c)(3) Dem resident abuse prev This REQUIREMEN by: Based on interview facility failed to prov training on resident nursing assistants (reviewed for abuse POLICY 2X Findings include: The Walker Rehab assessment dated staff would be educ Vulnerable Adult pc On 3/26/18, at 9:30 manager stated all	ities that constitute abuse, n, and misappropriation of s set forth at § 483.12. edures for reporting incidents exploitation, or the f resident property entia management and vention. NT is not met as evidenced v and document review, the vide the required annual abuse prevention for 4 of 5 (NA-B, NA-C, NA-D, NA-I) / vulnerable adult (VA) training. illitation and Healthcare facility November 2017, indicated all cated on the facility's dicy.		 F943 SS=E This Plan of Correction consti written allegation of compliant deficiencies cited. However, s of this Plan of Correction is no admission that a deficiency ex one was cited correctly. This Correction is submitted to mer requirements established by s federal law. It is the policy of the facilit trainings on abuse, neglect an exploitation requirements are upon hire and annually. The f to train on these requirements NA C, NA D, NA 1. Training h assigned by HR to these staff Relias learning to be complete 2. The facility has determine 	ce for the ubmission of an cists or that Plan of et tate and y to ensure id completed acility failed completed acility failed of or NA B, as been through ed by 5-6-18.
	- At 9:35 a.m. revie	w of employee records		residents have the potential to	

Facility ID: 00995

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245222		<u> </u>			
		245323	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	27/2018	
	PROVIDER OR SUPPLIER	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BC WALKER, MN 56484	X 700	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 943	Continued From pa	age 248	F 94	3			
	revealed the follow	ing:		by this deficient practice if staff a			
	NA-B was hired on 9/27/93. NA-B's Relias transcript indicated NA-B had not completed a V/ training course. NA-C was hired on 12/10/14. NA-C's Relias			 adequately trained on abuse, ne exploitation upon hire and annual staff must complete training requirements of abuse and neg 6-2018. Beginning 4/24/2018 HR processory 	ally. All uirements glect by 5-		
	training course.	NA-C had not completed a VA		Relias training modules for all st complete abuse, neglect and ex requirements by May 8th 2018.	aff to ploitation On 5/1/18		
		11/13/17. NA-D's Relias NA-D had not completed a VA		the DON (or designee) will provi with the resident safety manual reinforce information. A procedu been implemented for HR to set	to ure has		
		6/8/17. NA-I''s Relias NA-I had not completed a VA		 staff with new hires and annually assure enrollment, monitoring a completion being reviewed. 4. Audits will be completed we 	r to nd		
		e business office manager aware of how the staff were to ing.		staff to assure compliance, and employees during that time fram assure compliance and any defi noted will be corrected on the sp	e to ciencies		
	stated all staff men training annually w	00 a.m. the director of nursing hbers were to complete abuse hich was to be recorded in the ed training program.		educational status of employees added to review indefinitely and at every QAPI to assure monthly or Designee is monitoring all sta including contracted services an	ongoing / the HR ff		
	Minnesota Region policy and impleme comprehensive pol	rior Healthcare Management, Abuse Prevention Program entation form indicated icies had been developed to		volunteers to ensure that compli occurring. 5. The DON (or designee) will responsible for the POC.	ance is		
;	mistreatment to the would include polic	eventing abuse, neglect, or eir residents. The program y and procedures which imum: mandated staff					
	training/orientation topics as abuse pre reporting, dealing v	program which included such evention, identification, abuse vith violent behaviors and nt reactions etc A policy					

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DEPARTMENT OF HEALTH A				F	NTED: 05/04/2018 FORM APPROVED B NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
	245323	B. WING_			03/27/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
WALKER REHABILITATION & HEALTHCARE CENTER			209 BIRCHWOOD AVENUE WES WALKER, MN 56484	3T PO BOX 700		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIA		
provided. The undated Superior Minnesota Region, A Policy Interpretation indicated comprehen had been developed preventing abuse, ne residents. The abuse provides policies and as a minimum: mand programs which inclu- preventions, identific stress management, behaviors or catastro However, the policy	ining was requested and not or Healthcare Management Abuse Prevention Program and Implementation form nsive policies and procedures I to aid their facility in eglect or mistreatment of their e prevention program d procedures that governed, dated staff training/orientation uded topics such as abuse cation and reporting of abuse, , dealing with violent	F 94				

Facility ID: 00995

If continuation sheet Page 250 of 250

		AND HUMAN SERVICES & MEDICAID SERVICES		F	1212071	FORM	: 05/01/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				E SURVEY IPLETED
		245323	B. WING			03/20/2018	
NAME OF F	PROVIDER OR SUPPLIER		·[REET ADDRESS, CITY, STATE, ZIP CODE		
WALKER REHABILITATION & HEALTHCARE CENTER					99 BIRCHWOOD AVENUE WEST PO BOX 7 ALKER, MN 56484	00	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	ĸ	000			
	FIRE SAFETY						
	Minnesota Departm Fire Marshal Divisio the Walker Rehabil was found not in co requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I	articipation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC),					
		E AN EPOC, A PAPER COPY CORRECTION IS NOT					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
	Health Care Fire In State Fire Marshal 445 Minnesota Stre St. Paul, MN 55101	Division eet, Suite 145					
	Or by e-mail to both Marian.Whitney@s and Angela.Kappenmar	tate.mn.us			EPOC		
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 04/26/2018
Election	ically Signed						07/2010

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.

	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		MPLETED
		245323	B. WING		03/20/2018	
AME OF	PROVIDER OR SUPPLIEF	2		STREET ADDRESS, CITY, STATE, ZIP CO		
VALKEF	R REHABILITATION &	& HEALTHCARE CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 000	Continued From p	age 1	K 000			
	1. A description of to correct the defined	what has been, or will be, done siency.				
	2. The actual, or p	roposed, completion date.				
	responsible for co	or title of the person rrection and monitoring to rence of the deficiency				
	Golden Living Cer building with a par constructed at two building was cons determined to be of 1994, an addition side of the building Type II(111) const	urveyed as a single building. Inter of Walker is a 1-story tial basement. The building was o different times. The original tructed in 1967 and was of Type II(222) construction. In was constructed to the east g that was determined to be of ruction and separated with a 2 the main level is divided into 3				
	fire sprinkler syste with smoke detect open to the corride	otected by a complete automatic of and has a fire alarm system ion in the corridors, spaces or system and in common areas for automatic fire department				
		capacity of 35 beds and had a e time of the survey.				
	NOT MET.	at 42 CFR, Subpart 483.70(a) is				
14 004	Emergency Lightir		K 291			4/18/18

Facility ID: 00995

If continuation sheet Page 2 of 5

		AND HUMAN SERVICES		PRINTED: FORM OMB NO.	APPROVE	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		X3) DATE SURVEY COMPLETED	
		245323	B. WING	03/2	20/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
K 291	Continued From pa	age 2	K 29	1		
	is provided automa 18.2.9.1, 19.2.9.1 This REQUIREME by: Based on observa staff, the facility has emergency lighting maintained in acco "The Life Safety Co section 7.9.3. This 35 of 35 residents, number of staff, an	g of at least 1-1/2-hour duration atically in accordance with 7.9. NT is not met as evidenced tions and an interview with s failed to ensure that has been tested and rdance with the NFPA 101 ode" 2012 edition (LSC) deficient practice could affect as well as an undetermined d visitors in the event of an ation during a power outage.		1. The deficient practice occurred prior to the current Maintenance Supervisor's employment. Since identification of deficient practice, the Administrator initiated an Ad Hoc on 4-18-2018 to monitor emergency lighting testing bi-monthly to assure tests are completed monthly and brought to the quality assurance committee for review and continued monitoring until determined resolved.		
	on 03/20/2018, obs available testing an and an interview wi revealed that the fa 30 second monthly emergency lights fo	ween 11:30 a.m. to 3:30 p.m. servation during a review of all ad maintenance documentation ith the Maintenance Supervisor acility had not conduct 3 of 12 test of the battery operated bund within the facility.		 2. 4/18/2018 3. Administrator is responsible for monitoring audit, and Maintenance Supervisor is responsible for completed audit bi-monthly. Current temporary Administrator is Brooke Slaughter, and current Maintenance Supervisor is Jackie Foster. 		
	Fire Drills CFR(s): NFPA 101	, stan.	K 71	2	4/18/18	
F	signal and simulation conditions. Fire dril	ne transmission of a fire alarm on of emergency fire Is are held at expected and under varying conditions, at				

Facility ID: 00995

If continuation sheet Page 3 of 5

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245323	B. WING		03/2	20/2018
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALKEF	REHABILITATION &	HEALTHCARE CENTER		209 BIRCHWOOD AVENUE WEST PO BO WALKER, MN 56484	X 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
K 712	Continued From pa	age 3	K 712	2		
	established routine between 9:00 PM a announcement ma alarms. 19.7.1.4 through 19 This REQUIREME by: Based on review of interview, it was de to conduct several the NFPA 101 "The edition (LSC) section 12-month period. The affect 35 of 35 resi undetermined nume Findings include: On facility tour betw	ad is aware that drills are part of Where drills are conducted and 6:00 AM, a coded y be used instead of audible 9.7.1.7 NT is not met as evidenced of reports, records and staff termined that the facility failed fire drills in accordance with a Life Safety Code" 2012 on 19.7.1.6, during the last This deficient practice could dents, as well as an ber of staff, and visitors. ween 11:30 a.m. to 3:30 p.m. ring the review of all available		 Since identification of defici practice, the Administrator initiat Hoc on 4-18-2018 to monitor Ma Supervisor's fire drill testing bi-m assure tests are completed on c shift monthly, as well as verificat fire alarm signal as received by t monitoring company. This will be to the quality assurance commit review and continued monitoring determined resolved. 4/18/2018 	ed an Ad aintenance nonthly to orrect tion that the brought tee for	
	fire drill documenta maintenance staff conditions were for	ation and interview with a member the following deficient		3. Administrator is responsible for monitoring audit, and Maintenan Supervisor is responsible for con audit bi-monthly. Current tempo Administrator is Brooke Slaught	ice mpleted orary	
	 1 overnight shift fir 2. It was revealed to 	e drill in the third quarter. hat the facility did not conduct it shift fire drill in the fourth		current Maintenance Supervisor Foster.	is Jackie	
3 1 a	1 of 12 tests of the	hat the facility did not conduct DACT ensuring that the fire aceived by the monitoring				

Facility ID: 00995

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		245323	B. WING	71.44	03/20/2018	
	NAME OF PROVIDER OR SUPPLIER WALKER REHABILITATION & HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 209 BIRCHWOOD AVENUE WEST PO BOX WALKER, MN 56484	700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 712	Continued From pa	ge 4	K 71	2		
	This deficient condi Maintenance Super	tion was confirmed by a visor.				
Ĩ						

Facility ID: 00995

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PRINTED: 05/01/2018



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 17, 2018

Ms. Brooke Slaughter, Administrator Walker Rehabilitation & Healthcare Center 209 Birchwood Avenue West PO Box 700 Walker, MN 56484

Re: State Nursing Home Licensing Orders - Project Number S5323027

Dear Ms. Dillon:

The above facility was surveyed on March 19, 2018 through March 27, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Walker Rehabilitation & Healthcare Center April 17, 2018 Page 2 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 Lyla Burkman, Unit Supervisor at (218) 308-2104 or lyla.burkman@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minneso	ota Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE COMP	SURVEY LETED
		00995	B. WING		03/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
WALKEF	WALKER REHABILITATION & HEALTHCARE CI 209 BIRC WALKER			ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve- found that the defice herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wi corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	p participate in the electronic insure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
Minnesota D	epartment of Health	DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE		(X6) DATE
	ically Signed					04/26/18

6899

If continuation sheet 1 of 136

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/27/2018
		209 BIR(NUE WEST PO BOX 700	
VALKE	R REHABILITATION &	HEALTHCARE CI WALKER	R, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
2 000	Continued From pa	ige 1	2 000		
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 3/19/18 - 3/27/1 Department's staff the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 8, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for			
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follor are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA	RD THE HEADING OF THE			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY
		00995	B. WING		03/27/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
VALKEF	REHABILITATION &	HEAI THCARE C	CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 285	MN Rule 4658.0100 Orientation and In-S		2 285			5/8/18
	must provide in-ser education must be continuing compete address areas iden assessment and as must address the s determined by the r home must provide program in rehabilit to promote ambulat living; assist in activ of range of motion,	e education. A nursing home vice education. The in-service sufficient to ensure the ence of employees, must tified by the quality ssurance committee, and pecial needs of residents as nursing home staff. A nursing an in-service training ation for all nursing personnel tion; aid in activities of daily <i>i</i> ties, self-help, maintenance and proper chair and bed the prevention or reduction of				
	by: Based on interview facility failed to ensuinservice training w	ent is not met as evidenced , and document review, the ure 12 hours of annual as completed by 2 of 5 NA-B, NA-C) whose were reviewed.		corrected		
	Findings include:					
	record indicated sh	9/27/93. NA-B's employee e had completed zero of the hours from 9/27/16 to				

RI9311

If continuation sheet 3 of 136

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		03/	03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
VALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 285	Continued From pa	age 3	2 285				
	record indicated sh	12/10/14. NA-C's employee he had completed 2.75 of the g hours from 12/16/16 to					
		09 a.m. the director of nurses A's were to received 12 hours /ear.					
	Description/Compe indicated all NA's w	ied Nursing Assistant Job etency/Evaluations form vere to complete 23 hours of annually tracked from hire date					
	The director of nurs develop, review, an procedures to ensu- receive 12 hours of annually. The DON monitoring systems	THODS OF CORRECTION: sing (DON) or designee could nd /or revise policies and ure all nursing assistants f continuing education N or designee could develop s to ensure ongoing port those results to the quality tee.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			5/8/18	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related	lity serves persons with disorders, whether in a eral unit, the facility's direct					

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY PLETED
			A. BUILDING	:		
		00995	B. WING		03/2	27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	REHABILITATION &		HWOOD AV , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 302	Continued From pa	ige 4	2 302			
	care staff and their superviso care.	rs must be trained in dementia				
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				
	by: Based on interview failed to provide an resident Alzheimers for 4 of 5 nursing as	ent is not met as evidenced and record review, the facility annual required training on s Training / Dementia Training ssistants (NA-B, NA-C, NA-K, Alzheimer's training.		corrected		
	The facility assess Rehabilitation Heal indicated all staff m Alzheimers / demen	a.m. the business office				
		Relias computerized training				

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/	27/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVEN R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 302	Continued From pa	ige 5	2 302			
		mployee record were aled the following information:				
		n 9/27/93. NA-B's Relias NA-B had not completed a course.				
		12/10/14. NA-C's Relias NA-C had not completed a course.				
		6/8/17. NA-K's Relias NA-K had not completed a course				
		6./8/17. NA-I''s Relias NA-I had not completed a course.				
		business office manager ware if staff had received any imers training.				
	stated all staff men Alzheimers/Demen	0 a.m. the director of nursing nbers were to complete tia training annually. The ed in the Relias computerized				
	The administrator of review, and /or revi ensure all direct ca receive training on The administrator of monitoring systems	THODS OF CORRECTION: or designee could develop, se policies and procedures to re staff and their supervisors Alzheimers/dementia care. or designee could develop s to ensure ongoing port those results to the quality ee.	,			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE		
ALKER	REHABILITATION &		IWOOD AVEI MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE COMPLE HE APPROPRIATE DATE	
2 302	Continued From pa	age 6	2 302			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 540	MN Rule 4658.040 Resident Assessm	0 Subp. 1 & 2 Comprehensive ent	2 540		5/8/18	
	conduct a compreh resident's needs, w capability to perform significant impairm nursing assessmen Minnesota Statutes 15, may be used as resident assessmen comprehensive resi used to develop, re- comprehensive plat 4658.0405. Subp. 2. Inform comprehensive resi include at least the A. medically de medical history; B. medical stat C. physical and D. sensory and E. nutritional s F. special treat	tion; tential; n potential; atus; y; and				
	resident pre					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		
WALKER	REHABILITATION &		HWOOD AV	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 540	Continued From pa	age 7	2 540			
	facility failed to ensure completed for	v and document review, the sure Care Area Assessments r 2 of 12 residents (R13, R14) and/or significant change was completed.		corrected		
	Findings include:					
	7/24/17, indicated l impairment, require assistance for activ incontinence, no na was at risk for pres Assessment Sumn following CAAs we comprehensive ass	num Data Set (MDS) dated R13 had moderate cognitive ed limited to physical staff vities of daily living, urinary atural or fragmented teeth and soure ulcers. The Care Area nary (CAA) indicated the re identified as needing further sessment/investigation to equired interventions and care				
	Cognitive/Loss Fur Activity of Daily Liv Urinary Incontinent Falls Nutritional Status Dental Care Pressure Ulcer	ing/Rehabilitation Potential				
		edical record lacked evidence of the identified CAAs.				
	stated she was res assessments and t	5 p.m. registered nurse (RN)-E ponsible to complete the MDS the corresponding CAAs. RN-E /24/17, triggered CAAs were required.				
	director of nursing	ith the administrator and (DON) on 3/26/18, at 10:38				
nesota De	epartment of Health ⁄I		6899	RI9311	If continuati	on sheet 8 of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
VALKEF	REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPL THE APPROPRIATE DAT
2 540	Continued From pa	-	2 540		·
		tor stated it would be expected ompleted when triggered.			
	Region MDS/CAA I indicated would cor and stated requirer of the MDS and CA member to comple assessments and N CAAs and care pla	hcare Management Minnesota Policy effective 3/22/18, mply with all applicable federal nents related to the completion As and directed each team te their designated MDS sections along with the n for the items that are ection of the MDS for which			
	Review of the Long Assessment Instru- indicated: The RAI consisted Minimum Data Set Assessment (CAA) Guidelines. The Ca residents who had developing specific required further ass CAA was the further areas in order to de required intervention manual further indic completed in conju	a Term Care Facility Resident ment 3.0 User's Manual (RAI) of three basic components: (MDS) Version 3.0, Care Area process and RAI Utilization are Areas triggered identified been or were at risk for functional problems and sessment. The completion of a er investigation of the triggered etermine if the care area ons and care planning. The RA cated that CAAs must be nction with the completion of ssion, annual, and significant	I		
	R14 had moderate a fracture as a resu no inappropriate be limited assistance of ambulating in room assistance of one p	DS dated 1/26/18, indicated cognitive impairment, suffered ult of a fall prior to admission, chavior symptoms, required of one person when n, required extensive person for transfers, and assistance of one person for	1		

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/27/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKEF	R REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 540	Continued From pa	age 9	2 540			
	having books or ne around animals or	use. The MDS indicated wspapers to read, being pet visits, and participating in were somewhat important to				
	revealed the CAA h was no assessmen activity interests pri environmental or st participation, uniqu resident has that co	ndated CAA for activities nad not been completed. There it of current activity interests, for to admission, taffing issues that hindered e skills or knowledge the puld be passed onto others, or n reduced activity participation.				
	the CAA had not be CAA assessment of medications, diagn laboratory findings,	ndated CAA for falls revealed een completed. There was no of physical limitations, oses, history of falls, or environmental factors. was no analysis of the findings				
	interviewed on 3/22	or of clinical services was 2/18, at 8:29 a.m. during which 's CAA's for activities and falls completed.				
	The director of nurs develop, review, an procedures to ensu completed in accor Instrument Manual educate all appropri designee could dev ensure ongoing con	THODS OF CORRECTION: sing (DON) or designee could ind /or revise policies and ure care area assessments are dance to the Resident . The DON or designee could riate staff. The DON or velop monitoring systems to mpliance and report those y assurance committee for lations				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
AME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE	
/ALKEF	R REHABILITATION &		IWOOD AVEI MN 56484	NUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLI HE APPROPRIATE DATE
2 540	Continued From pa	age 10	2 540		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
2 625	MN Rule 4658.045 Contents; In Gener	0 Subp. 1 A-P Clinical Record al	2 625		5/8/18
	record, including n A. the condition admission; B. temperature pressure, according subpart 2, item C. the resident according to part 4 D. the resident and attitudes; E. observation interventions provid responsible for care of the confidential commu- religious perso F. significant o behavior, orientation nursing home, G. date, time, o method of administ the signature o persons who admin H. a report of a three months prior in part 4658.08 I. reports of lat J. dates and tin dressings;	I's height and weight, 4658.0520, subpart 2, item J; 4's general condition, actions, s, assessments, and ded by all disciplines resident, with the exception of unications with nnel; bservations on, for example, on, adjustment to the judgment, or moods; quantity of dosage, and tration of all medications, and of the nurse or authorized histered the medication; a tuberculin test within the to admission, as described a10; boratory examinations; mes of all treatments and mes of visits by all licensed			

TATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03//	27/2018
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
VALKEF	R REHABILITATION &		HWOOD AV 8, MN 56484	ENUE WEST PO BOX 700		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLET
PRÉFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE
2 625	Continued From pa	age 11	2 625			
	L. visits to clini	cs or hospitals;				
		or instructions relative to the				
	comprehensive pla					
		in the resident's sleeping				
	habits or appetite;	store regarding shanges in the				
	resident's general of	ctors regarding changes in the				
		e initial comprehensive				
		nt and all subsequent				
		e assessments as described in				
	part 4658.0400.					
	-	ent is not met as evidenced				
	by:					
		and document review, the sure clinical records were		corrected		
		rate for 7 of 20 resident (R5,				
		R21, R225) records reviewed.				
		tial to affect all 23 residents				
	residing in the facili	ity.				
	Findings include:					
	R5's medical record wound care.	d did not accurately reflect				
		5 p.m. registered nurse (RN)-D				
		move a Duoderm dressing				
		Upon removal of the dressing	3			
		o newly opened areas under O measured the first open area				
		to be 1 cm x 0.3 cm. The				
		noted on the lower left				
		1 2 cm by 2 cm. The three				
	areas under the dre	essing approximately 1 inch in				
		erved to be deep red/purple in				
		blanchable. RN-D stated the				
	wound had change	ed appearance since the last				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE	
VALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVEN R, MN 56484	NUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE
2 625	Continued From pa	ge 12	2 625		
		ved it. RN-D stated the open d the wound looked worse.			
		ical record on 3/23/18, lacked ted to the wound care and n 3/21/18.			
	record and confirm completed any type	a.m. RN-E reviewed R5's ed the facility had not of documentation related to open areas identified on			
	had not completed	a.m. RN-D confirmed she any type of documentation inds treated on 3/21/18. RN-D it."			
	indicated R5 had a was yellow/green in surrounding the bru not identify where the origin of the bruise.	e dated 3/13/18, at 11:20 p.m. 6 cm by 3 cm bruise which a color with some pinkness uise. The documentation did he bruise was located or the No further documentation e was noted in R5's record.			
	Review of R2's clin following information	ical record revealed the n:			
	indicated R2 did no weight on his/her let tolerate a semi-rect was to be transferred name of a full body the form was incom not been assessed	atus form dated 12/31/17, t have the ability to bear egs. R2 did have the ability ined position and indicated R2 ed with a MaxiMove (brand mechanical lift). The rest of plete, as it was blank. R2 had to identify the appropriate size tify the number of staff t to transfer R2.			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
009		00995	B. WING		03/	27/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &		HWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 625	Continued From pa	age 13	2 625			
	An incident report dated 9/15/17, indicated R2 had sustained a skin tear on her left inner elbow while being transferred with a mechanical lift which required first aid. The documentation did not identify the root cause of the injury, the number of staff members present at the time of the injury or interventions to minimize further injuries.					
	had sustained a sk hand while being tr mechanical lift. Th identify the root cau staff members pres	dated 10/29/17, indicated R2 in tear on the back of the right ansferred via a full body e documentation did not use of the injury, the number of set at the time of the injury or nimize further injuries.				
	had sustained a sk hand while being tr mechanical lift. Th identify the root cau	dated 11/15/17, indicated R2 in tear and bruise on her left ansferred via a full body e documentation did not use of the injury, the number of sent at the time or interventions injuries.				
		2's clinical record lacked ted to the identified injuries.				
	clinical services (RI not have any furthe R2's injuries and th	i0 a.m. the regional director of DCS) confirmed the facility did er documentation related to be number of staff members of the injuries was unknown.				
	stated she had ider documentation in the attempting to train so improve documentation	05 a.m. the administrator ntified a concern with ne facility and had been staff members on how to ation. The administrator rould be developing an action				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00995	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
/ALKEF	R REHABILITATION &	HEAI THCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 625	Continued From pa	ige 14	2 625			
	plan to ensure com documentation.	plete and accurate				
	was to utilize a plat	ated 1/20/17, indicated R23 e guard for meals to ensure t greater than or equal to 75%				
	On 3/19/18, at 12:05 p.m. R23 was observed to be served the noon meal. R23's plate was not equipped with a plate guard.					
		5 p.m. R23 was observed to meal. R23's plate was not ite guard				
		p.m. R23 was served the s plate was not equipped with				
		5 p.m. R23 was served the plate was not observed to				
	any type of adaptive was identified on th Review of R23's die type of adaptive eq had an order for a p was discontinued a at the time, R23 wa himself. The DM st	dietary manager (DM) stated e equipment required at meals re resident dietary card. etary card did not identify any uipment. The DM stated R23 olate guard in the past, but it bout six weeks ago because as not attempting to feed ated the nurses should have scontinuation of the plate				
	Review of R23's cli documentation rela the plate guard.	nical record lacked ted to the discontinuation of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00995		B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 625	Continued From pa	ige 15	2 625			
	was unaware of the R23 was to be utiliz stated she would re information related discontinuation, but documentation had	p.m. the DON stated she type of adaptive equipment ing at meals. The DON eview R23's record for further to the plate guard t to her knowledge, no been completed. No further ovided regarding R23's plate				
	R6's clinical record to the pacemaker n	lacked documentation related nonitoring.				
	having a pacemake care plan did not di	ed 6/28/17, identified R6 as er due to atrial fibrillation. The rect the staff to assist to aker via telephonic monitoring				
	R6's clinical record to the pacemaker n	lacked documentation related nonitoring.				
	confirmed R6 had a scheduled telephor completed by the n scheduled times we electronic medicatio (EMAR). LPN-B re	sed practical nurse (LPN)-B a pacemaker and stated the nic monitoring were to be ursing staff. LPN-A stated the ere to be identified on the on administration records viewed R6's EMAR and stated nclude pacemaker monitoring.	ł			
	room and located a monitoring device.	B entered the medication pacemaker telephonic LPN-B confirmed she had no 6 utilized the machine.				
		0 a.m. RN-E confirmed R6's and documentation related to luations.				
	On 3/27/18, at 9:25	a.m. LPN-A stated the				

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
00995		00995	B. WING		03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 625	Continued From pa	age 16	2 625			
	then identified R6 h 2/13/18. LPN-A st the pacemaker che completion of the p clinic staff directed monitoring was to t calendar, LPN-A st scheduled pacema months.	ht book at the desk. LPN-A had a pacemaker check on ated she had not completed eck. LPN-A stated that upon bacemaker monitoring, the the staff as to when the next ake place. Upon review of the ated R6 did not have a ker check in the next six				
	the pacemaker che 2018, however, sh monitoring in the m on 3/19/18, at 9:24 be his roommate a doors from him, ho with R21. R13 stat "beat him up" most ago. R13 stated ab was by the nursing had "rolled up and shoulder." R13 dei the staff who had w he had to "settle do of R21 and stated '	D stated she had completed eck via telephone in February e had not documented the nedical record. During interview a.m. R13 stated R21 used to nd currently lived a couple wever, he could not get along red R21 would threaten to recently being just two days out two months ago, when he station with staff present, R21 punched him in the left nied being injured. R13 stated vitnessed the incident told R21 own." R13 denied being afraid 'all he is, is one big mouth" stay away from R21 as much				
	R13 used to be roc and would swear a separate rooms. N would wheel past F R13 names and ha aforementioned alt R21. However, R13	p.m. NA-B stated R21 and ommates who did not get along t each other so they got A-B stated currently, when R13 R21's room, R21 would call id also witnessed the ercation between R13 and 3's and R21's clinical records the resident to resident				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00005	B. WING		00/07/0040
		00995			03/27/2018
IAME OF F	PROVIDER OR SUPPLIER				
VALKER	REHABILITATION &		R, MN 56484	NUE WEST PO BOX 700	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	THE APPROPRIATE DATE
				DEFICIENC	(Y)
2 625	Continued From pa	age 17	2 625		
	altercation.				
	During review of th	e facility's computerized risk			
		ent list, an incident whereby			
	R225 had eloped fi	rom the facility was noted and			
	•	rned R225 to the facility,			
		0/18, at 6:30 p.m. Cook (C)-A			
		ot happy about being at the bed from the facilty a couple of			
		he incident with the police			
	department was not the only time R225 had				
		empted to leave the facility. C-A	A		
		cident which occurred "way"			
		epartment incident, where he k up R225 after he had left the			
		wntown at a gas station which			
		e police department. C-A			
		had called the facility and			
		hat one of their residents was			
		at "somebody" had given R225			
		acility before he could go get 25 used a wheelchair and			
		get downtown by wheeling			
		hiddle of the street as that was			
		e road that had been plowed			
		snow fall. C-A remembered			
		priately dressed for the cold			
		. R225's clinical record lacked pement and frequent, daily			
	attempts to elope.	pomont and noquont, daily			
) p.m. the administrator and			
		egional director of clinical /ere informed of the altercation			
		were unaware the altercation			
		was not noted in the clinical			
		m. the RDCS, administrator			
		rmed R225 had eloped from			
		occasion, however was not			
		ous elopement which occurred			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00995				E CONSTRUCTION		E SURVEY PLETED
		B. WING		03/	27/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEAI THCARE C	HWOOD AVI	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 625	Continued From pa	ge 18	2 625			
	prior to employmen	t at the facility.				
	Region Medical Re procedure dated 12	hcare Management Minnesota cords Safeguarding policy and 2/23/17, did not address the f a resident's medical record.				
	The director of nurs develop, review, an procedures to ensu accurate document residents. The DON all appropriate staff develop monitoring compliance and rep	HODS OF CORRECTION: sing (DON) or designee could d /or revise policies and the complete, timely, and ation was kept current for all N or designee could educate The DON or designee could systems to ensure ongoing port the monitoring results to ce committee for further				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 685	MN Rule 4658.046 and Death	5 Subp. 2 Transfer, Discharge,	2 685			5/8/18
	transferred or disch than death, the nur discharge summary time of transfer or o	charge. When a resident is harged for any reason other sing home must compile a y that includes the date and discharge, reason for transfer fer or discharge diagnoses,				
	by: Based on interview facility failed to ens plan was developed	ent is not met as evidenced , and document review, the ure an appropriate discharge d and implemented for 1 of 1 was discharged to home.		corrected		

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00995		B. WING		03/27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	
VALKER	R REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE DATE
2 685	Continued From pa	age 19	2 685		
	Findings include:				
	diagnoses that incluing a contract of the second se	to the facility on 12/15/17, with uded but were not limited to: a procedure, cerebrospinal eneralized muscle weakness,			
	12/14/17, indicated for a CSF leak follo resulting infection. and sent to the nur- antibiotics until 12/2	ital dismissal summary dated R24 underwent a dural repair owing a lumbar fusion with a R24 was given IV antibiotics sing home to receive IV 21/17. R24 was admitted with ly inserted central catheter)			
	progress note date going to discharge driving herself in he indicated R24 want to a Walgreens clos note also identified with her primary ca health care and foll discharge planning which indicated R2 personal car at 10: brace and was able living (ADL's) indep indication if R24 wa and doff the back b PICC, if R24 could dressing on the low dressing supplies to	scharge planning revealed a d 12/20/17, indicating R24 was on 12/21/17, or 12/22/17, via er personal car. The note ted her medications to be sent se to where she lived. The R24 would would be working re physician to set up home ow-up appointments. The next note was dated 12/22/17, 4 discharged home via 00 a.m. R24 wore a back to perform activities of daily bendently. There was no as able to independently don orace, who would care for the independently change the ver spine or if R24 had to change the dressing. was no evidence of teaching of			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00995		B. WING		03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE C	HWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 685	Continued From pa	age 20	2 685			
	indication R24 received medications, what those medications were, and if R24 had been educated on those medications. Although R24 indicated a need for home care, there was no indication a referral to a home health agency had been completed and if R24 was accepted for admission.					
	Post-Discharge Pla found in R24's clos incomplete. The su home health agence names of two agen numbers were lister	charge Summary and an of Care dated 12/22/17, was ed record. The summary was immary indicated R24 wanted by recommendations and the cies and their telephone d. However, there was no encies were contacted.				
	(DON) stated the fa discharging resider teaching should ha indicated if R24 wa back brace, if R24 change the dressin had discharge med	4 a.m. the director of nursing acility did not have a system for hts. The DON stated patient ve been documented and s able to don and doff the was able to independently g on the lower spine, if she lications and what they were,				
	care should have b and a referral to a b have been initiated signs and symptom been reviewed, and physician phone nu provided. The DON a discharge policy a	Id have been pulled or home een set-up to ensure it's care, nome health agency should and set-up. Additionally, the ns of infection should have d the surgeon and primary care imbers should have been I stated the facility did not have and procedure at the time of				
	and procedure date SUGGESTED MET	nd provided a discharge policy ed 12/23/17. THODS OF CORRECTION: sing (DON) or designee could				
nonoto D	epartment of Health	sing (DOIN) of designee could				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
00995		B. WING		03/27/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVI , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 685	develop, review, an procedures to ensu completed for all di or designee could e The DON or design systems to ensure report results to the for further recomme	nd /or revise policies and ure recapitulations were scharged residents. The DON educate all appropriate staff. nee could develop monitoring ongoing compliance and e quality assurance committee	2 685			
2 800	Staffing requirement Subpart 1. Staffing home must have or number of qualified registered nurses, I nursing assistants to residents at all nurs in all buildings if more	requirements. A nursing n duty at all times a sufficient I nursing personnel, including licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends,	2 800			5/8/18
	by: Based on observati review, the facility f staffing was availab assistance with inco of motion services, turning and repositi residents' assessed care plan. This lack	ent is not met as evidenced ion, interview and document ailed to ensure sufficient ole in order to provide timely ontinence cares, provide range and timely assistance with ioning according to the d need and as directed by the c of sufficient staff had the II 23 residents who resided in		corrected		

STATEMEN	<u>ta Department of He</u> IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
	00995		B. WING		03/27	/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKEF	R REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 800	Continued From pa	age 22	2 800			
	Findings include:					
	review, the facility f assistance with inc residents (R2, R23 on staff for incontin provide grooming a	ion, interview and document ailed to provide timely ontinence cares for 2 of 2) who were totally dependent ence cares and failed to assistance for 1 of 2 male o required staff assistance to				
	review, the facility f repositioning as dir 4 residents ((R5, F had a pressure ulco	ion, interview and document ailed to provide timely ected by the care plan for 4 of R18, R2, R23) who currently ers or were at risk for the essure ulcers. See F686.				
	review, the facility f motion services as decline on range of residents (R5, R2) services. The failur resulted in actual h	ion, interview and document ailed to provide range of directed in order to prevent a motion abilities for 2 of 5 observed for range of motions e to provide the services arm for R5 and R2 who had e in range of motion abilities.				
	Residents:					
	orientated resident services, stated she periods of time (mo assistance. R3 stat could not always we her to get onto the once assisted onto	i9 a.m. R3 an alert and who received hospice e had to sometimes wait long ore than 10 minutes) for staff red she took a diuretic so she ait for staff assistance to help bedside commode. R3 stated the commode, she would just transfer herself back off				

RI9311

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Minnesc	ta Department of He	alth			-	-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	
		00995	B. WING		03/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVE , MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	pain, and/or shortnee the commode too lot there were only two evening shifts and i walk by without offee were running arourn periods were in the meals, and at bedti when she had to way was only one aide. about the safety for emergency situatio emergency situatio emergency would of and questioned whitwo emergencies a At 9:14 a.m. R21, a stated the facility di members to provide there were only two nurse on most wee he/she had turned for assistance, he/s time for the staff to busy. At 10:45 a.m. famili his/her loved one of receiving assistance	ess of breath from sitting on ong waiting for help. R3 stated aides on during the day and the nurses seemed to just ering to help while the NAs id. R3 stated the longest wait morning, before and after me, but stated night shift was ait the longest because there R3 stated she was concerned other residents in case of an in like a fall, because the consume the available staff at would happen if there were t one time. In alert and oriented resident, d not have enough staff e resident cares. R21 stated o nursing assistants and a kends therefore R21 knew if his/her call light on to summon she would have to wait a long come because they are so y member (FM)-B stated ould go 3-4 days without e with personal shaving	2 800			
	loved one was not i was unsure if the if not. At 11:48 a.m. R18 s was enough staff a to wait longer for as shift. R18 further st	d she was unsure why her receiving the assistance and the facility had enough staff or stated, she didn't think there vailable, and seemed to have ssistance on the overnight ated staff did not always y and they could probably offer				
Minnesota D	more often. epartment of Health					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		03/	03/27/2018	
AME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
ALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 24	2 800				
	Staff:						
	(NA)-C stated the fa only two NA's to pro- day and evening sh one NA. NA-A state get the residents' b stated the NAs wer of motions exercise however, this was r there was not enour On 3/22/18, at 6:34 stated didn't feel lik assistants to take of stated management and had put a mana- temporary staff was which seemed to he had been hired. State scheduling was bas of the residents. RN have three aides du shifts and one aide and that seemed a indicated concerns situations during the around and the level when only one nurs short handed, staff RN-A further indicated available to help fee assistance.	a.m. registered nurse (RN)-A te there was enough nursing care of the residents. RN-A at was aware of the concerns dating policy into place and s contracted for a few weeks elp, and then a couple of staff ated staff was told staff sed on census and not acuity N-A stated the facility used to uring the day and on evening on during the overnight shift, lot more sufficient. RN-A pertaining to emergent e night shift with only two staff el of acuity, stated often times se was scheduled or worked were not able to take breaks. ted meal times were se there wasn't enough staff ed the residents who required					
	not have time to co	a.m. NA-B stated the NAs did mplete documentation of ause they were too busy					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00995	B. WING		03/27/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		1 00,	21/2010
		209 BIR(NUE WEST PO BOX 700		
VALKER	REHABILITATION &		R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 800	Continued From pa	age 25	2 800			
	toileting and reposi residents, however those care tasks tir stated the NAs did of motions exercise there was not enou - At 9:32 a.m. licen stated the NAs wer answering call light not have the time to two hour cares as o LPN-B stated "they enough time in the stated when a NA o assigned day shift, work as a NA which complete all the nu meal times were th number of staff req LPN-B stated the s could and confirme receive assistance.	sed practical nurse (LPN)-B re busy all day long. Between is and providing cares, they did o provide assistance with every directed by the care plans. r can not do it, there is not day to get it done." LPN-B did not show up for their one of the wing nurses would n left only one nurse to rsing duties. LPN-B stated the e most difficult because of the juired to assist the residents. taff did the very best they ed the residents' did not always , exercises, shaving or oral				
	staffing at the facilit time, the facility has RN-B stated 10 of t required mechanica body) to transfer ar assistance of at lea In the past, the faci NAs during the day staff were able to ti	to r starr. 10 a.m. RN-B stated the ty was a challenge. At this d many dependent residents. the 23 current residents al lifts (either standing or full ast one staff to complete cares ility had two nurses and three and evening shifts and the mely assist the residents with ds and exercises. RN-B stated				
	due to a lower cens reduced, however,	sus the staffing had been when it was reduced from ne resident care acuity was not				

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/	27/2018
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &			NUE WEST PO BOX 700		
o			R, MN 56484			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ige 26	2 800			
	taken into consider	ation.				
	was the worst she l	a.m. NA-B stated the staffing nad seen in many years and with the current staff to				
	facility had utilized a agency who provide facility, however, the the facility several w	B stated in the past, the a supplemental nursing ed pool staff to work in the e pool staff had quit working a weeks ago, and the facility had LPN-B stated the staff d.				
	director of nursing of facility staffing. The hired on 1/17/18, and administrator that his staff recruitment and stated immediately the ineffective dissed and was currently in and implementation the staff members administrator stated appointed on 2/5/18 staff recruitment and nursing assistant his evening shifts and new scheduled possi positions were filled to help the nursing	a.m. the administrator and (DON) were interviewed about a administrator stated she was nd was told by the previous its main focus had been on ad staffing. The administrator upon hire, she had recognized emination of the licensed staff in the process of reorganization of new job roles according to scope of practice. The d the current DON was 8, and immediately started on ad scheduling activities. The bowledged the need for more ours during the day and was in the process of creating ditions. However, until those d, she expected licensed staff assistants with resident cares	i			
	Additionally, the ad requested assistan	he residents at meal times. ministrator stated she had ce from the corporate office to er, her request was not				

ATEMENT OF DEFICIENCIE	ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00995	B. WING	B. WING		27/2018
AME OF PROVIDER OR SUF	PPLIER STREET	ADDRESS, CITY, S	TATE, ZIP CODE	• • •	
ALKER REHABILITAT	ION & HEALTHCARE C	RCHWOOD AVE ER, MN 56484	NUE WEST PO BOX 700		
REFIX (EACH DEF	RY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800 Continued Fr	om page 27	2 800			
improvement a prioritization The plan iden needed base staffing goal a -three nursing staff with a w one to two aid census and a one 8 hour LF hour LPN for for the facility at local hospi running adve on 1/15/18, for	uality assurance and performance (QAPI) log dated 1/16/17, identified in plan for increasing staffing needs tified what staffing levels were d on census and acuity with the as: g assistants for morning shift, two ard assistant on the evening shifts des on the overnight (depending o locuity of residents), one 12 hour RI PN, and one 12 hour RN and one 8 day/evening shifts. The staffing pla- included social services marketing tals for appropriate residents, rtisements for staff, signed contract or two temporary nursing assistant ng assistance from the corporate	s. n N, 3 an g			
indicated the residents. Th services the f diseases/con identified the identifying the and resource and percenta identified nun needed was f hours for licer number of dir The assessm compare staf assistant hou	ssessment last revised 3/19/18, average daily census of 20-25 e assessment indicated care and facility could provide included ditions and cognitive disabilities ar acuity of the current residents by em by level of assistance required utilization group (RUG) categories ges. The facility assessment ober of nursing assistant hours between 48-72 hours per day and nsed staff per day with a total rect care hours per day as 80-104. then also included the nursing hom fing report which indicated nursing rs per resident day were less than ional averages.	3 32 e			
	census reports for February and effected the following:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 28	2 800			
	census was 18. Av per day was 43.02. this time period refinursing assistants evening shifts (2.39 hours per resident From 2/17/18-2/28/ census was 18. Av per day was 39.13.	/18, average daily resident erage nursing assistant hours The daily census sheets in				
	nursing assistants evening shifts (2.17 hours per resident					
	census was 22. Ave per day was 39.52 sheets in this time two nursing assista	8, average daily resident erage nursing assistant hours hours. The daily census period reflected an average of ints worked on the day and 9 nursing assistant direct care day).				
		e Management Minnesota Staffing policy included the				
		s adequate staffing to meet ervices for our resident				
	each shift to ensure services are met. L and licensed nursin and monitor the de 2. Certified nursing	tains adequate staffing on e that our resident's needs and icensed registered nursing ng staff are available to provide livery of resident care services assistants are available on e the needed care and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00005	B. WING		02/07/2040	
		00995		03/27/2018		
AME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE NUE WEST PO BOX 700		
ALKER	R REHABILITATION &	HEALTHCARE C	R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMP HE APPROPRIATE DAT	
2 800	Continued From pa	age 29	2 800			
	resident's compreh	sident as outlined on the ensive care plan. ased on resident census and				
	The administrator of review, and /or revi ensure sufficient, c available to care fo administrator or de monitoring systems					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	•			
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830		5/8/18	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.	1 t			
	This MN Requirem by:	ent is not met as evidenced				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00995	B. WING		03/2	7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE C	HWOOD AVI MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 30	2 830			
	review, the facility facemaker function	on, interview, and record ailed to ensure routine nality checks had been 1 resident (R6) reviewed who acemaker.		corrected		
	1/17/18, identified F impairment and dia disorder, chronic at disease. The MDS limited assistance c daily living. R6's Hospital Disch	num Data Set (MDS) dated R6 with moderate cognitive gnoses including: depressive rial fibrillation and mitral valve also indicated R6 required of one staff for all activities of parge Summary dated 6/19/17,				
		o complete a pacemaker check using a remote home monitor				
	pacemaker due to a the staff to monitor altered cardiac outp such as dizziness, s pulse rate lower tha than baseline blood	d 6/28/17, identified R6 had a atrial fibrillation and directed for signs and symptoms of out or pacemaker malfunction syncope, difficult breathing, in programmed rate or lower pressures. The care plan did o assist to monitor the phonic monitoring.				
	R6's clinical record to the pacemaker n	lacked documentation related nonitoring.				
	ambulate approxim assistance of one s observed to display or fatigue while wal	a.m. R6 was observed to ately 125 feet with stand by taff member. R6 was not shortness of breath, dizziness king.				
<i>Minnesota</i> D	epartment of Health					

RI9311

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
IAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE NUE WEST PO BOX 700	
VALKER	REHABILITATION &		R, MN 56484	NUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
2 830	Continued From pa	nge 31	2 830		
	confirmed R6 had a scheduled telephor completed by the n scheduled times we electronic Medicatio (EMAR). LPN-B re the EMAR did not in - At 1:17 p.m. LPN- room and located a monitoring device.	sed practical nurse (LPN)-B a pacemaker and stated the nic monitoring was to be ursing staff. LPN-A stated the ere to be identified on the on Administration Records eviewed R6's EMAR and stated nclude pacemaker monitoring. -B entered the medication a pacemaker telephonic LPN-B confirmed she had no 26 utilized the machine.	1		
	R6's clinical record lacked documentat checked. RN-E sta into the concern.	tered nurse (RN)-E reviewed and stated the clinical record ion as to the last time it was ated she would have to look 0 a.m. RN-E confirmed R6's			
		ked documentation related to			
	pacemaker monitor nurse's appointment then identified R6 h 2/13/18. LPN-A st the pacemaker cher completion of the p clinic staff directed monitoring was to t the calendar, LPN-	a.m. LPN-A stated the ring was scheduled in the nt book at the desk. LPN-A had a pacemaker checked on ated she had not completed eck. LPN-A stated that upon acemaker monitoring, the the staff as to when the next ake place. Upon review of A stated R6 did not have a ker check in the next six			
	the pacemaker che	D stated she had completed eck via the telephone in wever, she had not			

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/2	27/2018
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
ALKER	REHABILITATION &		HWOOD AVEI , MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI	ON SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TI DEFICIENCY		DATE
2 830	Continued From pa	age 32	2 830			
	RN-D stated at the additional appointm RN-D stated the fa- of documentation fi which would indical pacemaker. RN-D clinic to contact the - At 9:50 a.m. the S was interviewed via stated R6's pacema 2/13/18, and R6 was evaluation. R6 would appointment in the review. - At 10:51 a.m. RN- to R6's family mem- be seen in the clinic	onitoring in the medical record. time of the monitoring, an nent had not been made. cility had not received any type rom the pacemaker clinic te any concerns with the stated she would expect the e facility if there was a problem. Sanford Pacemaker Clinic staff a telephone. The clinic staff aker check was completed on as due for a cardiologist and be scheduled an next two months for further -D stated he/she had spoken aber who was aware R6 was to c for a cardiac evaluations. e facility was not aware of the				
	The director of nurs develop, review, an procedures to ensu- residents with spec- provided. The DOI all appropriate staff develop monitoring compliance and rep assurance committed	THODS OF CORRECTION: sing (DON) or designee could nd /or revise policies and ure appropriate care of cial clinical needs was N or designee could educate f. The DON or designee could systems to ensure ongoing port those results to the quality				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		IDENTIFICATION NOWIDER.	A. BUILDING:		
		00995	B. WING		03/27/2018
AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
ALKER	REHABILITATION &		HWOOD AVI , MN 56484	ENUE WEST PO BOX 700	
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2 895	Continued From pa	ge 33	2 895		
2 895	MN Rule 4658.0528 Motion	5 Subp. 2.B Rehab - Range of	2 895		5/8/18
	through positioning implemented and m comprehensive res of nursing services development of a n provides that: B. a resident with receives appropriat	ard prevention of deformities and range of motion must be haintained. Based on the ident assessment, the director must coordinate the ursing care plan which h a limited range of motion e treatment and services to notion and to prevent further of motion.			
	by: Based on observati review, the facility fa motion services as the decline in range 2 of 5 residents (R5 decline in ROM. Th services resulted in development of upp actual harm for R2 contractures in the facility failed to asse services for 1 of 5 r limitations in ROM of development of a R	ent is not met as evidenced on, interview and document ailed to provide range of directed in order to prevent e of motion (ROM) abilities for 5, R2) observed to have had a e lack of the provision of the actual harm for R5 due to the ber extremity contractures; and due to the development of lower extremities. Lastly, the ess the need for ROM esidents (R23) observed with without the assessment and ROM program in order to r maintain current ROM		corrected	
	Findings include				
	R5's quarterly Minin	num Data Set (MDS) dated			

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		00995	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	REHABILITATION &	209 BIR(NUE WEST PO BOX 700		
		WALKEF	R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	nge 34	2 895			
	impairment and dia Parkinson's diseas depression. The M assistance of two s and all activities of functional limitation upper and lower ex MDS dated 9/1/17, upon staff for all ac bilateral functional and lower extremiti R5's Activities of Da Assessment (CAA) required total staff living related to end damage or malfund	IDS indicated R5 required tota taff for bed mobility, transfers daily living, and had bilateral in range of motion of the tremities. R5's admission indicated R5 was dependent tivities of daily living and had limitation in ROM of the upper es. ally Living Care Area dated 9/6/17, indicated R5 assistance all activities of daily cephalopathy (brain disease, ction), spinal fusion and AA indicated R5 was				
	dated 9/14/17, indic contractures of the The physical therap complete upper an	gress and Discharge Summary cated R5 had bilateral upper and lower extremities. oist directed the nursing staff to d lower extremity range of order to maintain mobility.				
	limited physical mo	ed 8/25/17, indicated R5 had bility and directed the staff to je of motion with daily cares.				
	stated she was not type of range of mo R5's arms began to an accident which n FM-A stated R5 has the accident, howe	5 a.m. family member (FM)-A aware of R5 receiving any otion services. FM-A stated o contract one year ago after resulted in R5's quadriplegia. d received therapy right after ver, had not received any nce that time. FM-A stated R5				

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AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
ALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
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2 895	Continued From pa	age 35	2 895			
	were getting worse observed seated in elbow braces on. T inner aspect of the extended to the mi- were covered with secured with veloco- prevented further fl R5's elbows were i hands rested in a fl - At 12:40 p.m. NA- residents and only to all the residents shifts. One NA wo stated the NAs wer with basic cares bu services. NA-C sta provided during the	-C stated the facility had 23 two NAs to provide direct care during the day and evening rked on the night shift. NA-A re able to provide the residents at did not provide ROM ated ROM exercises were to be provision of morning caress, s] did not have to time				
	room, seated in a w braces on. NA-B st straighten/extend h move them a few in	B7 p.m. R5 was observed in his wheelchair, with bilateral elbow tated R5 was not able to fully his arms rather was only able to nches. R5 was observed to s which also moved his arms inches.				
	with evening cares bilateral arm brace his chest and his h position. NA-D pro elbow moving it slig shirt sleeve. While unable to extend a	D was observed to assist R5 . When NA-D removed the s, R5's arms curled tightly to ands remained in a fisted beceeded to lift up R5's right ghtly in order to remove R5's lifting the elbow, his arm was nd his shoulder moved less vay from R5's body resulting in				

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AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE. ZIP CODE		
		209 BIR(NUE WEST PO BOX 700		
VALKER	REHABILITATION &	HEALTHCARE C WALKER	R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ige 36	2 895			
	NA-D maneuvering NA-A slipped the sl off of the left arm. observed to move w NA-D proceeded to When washing the extend his right fing degree angle. R5's fixed with NA-D onl NA-D again washed was open with his f degree angle and w further. NA-D comp R5 in a hospital gov arms, elbows and so observed to provide exercises. - At 6:16 p.m. NA-E did not provide the because the day sh programs/exercises On 3/21/18, at 9:19 been the NA assign functional mainten by the physical ther 2018, she was rem reassigned to provi NA-C stated R5 ha maintenance progr that there is not a s provide the rehab so directed to provide provision of person simply did not have services in addition On 3/21/18, at 9:21	his shirt sleeve off his arm. hirt over R5's head and slid it R5's left arm was not while the shirt was removed. wash R5's hands and arms. hands, R5 was noted to gers to an approximately 90 s right hand fingers appeared by washing between his fingers d R5's left hand as his hand ingers extended to a 45 vere unable to extend any oleted the cares by dressing wn and applying lotion to R5's shoulders. NA-D was not e R5 any upper extremity ROM D stated the evening shift staff residents' any ROM exercises hift staff completed the ROM s. 0 a.m. NA-C stated she had hed to provide the residents' ance programs as established rapist. However, in February oved from rehab services and de resident personal cares. d had a functional am in the past, however, now specific employee assigned to services, the NAs were the ROM services during the al cares. NA-C stated the staff e the time to provide ROM to routine personal cares.				
	(LPN)-B confirmed	Lin had not been receiving	1			1

Minnesc	ta Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMP	SURVEY LETED
		00995	B. WING		03/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ige 37	2 895			
	getting more difficu because his arms v contractures were g -At 9:30 a.m. regist could not recall R5 motion services and	stated due to this, it had been It to apply R5's elbow braces were more stiff and his getting tighter. ered nurse (RN)-D stated she ever having received range of d confirmed the braces were bly due R5's increased				
	stiffness of his upp					
	Treatment Administ indicated the nursir braces at night and	ctronic Medication and tration Record dated 3/2018, ng staff were to apply hand elbow braces during the day. t direct the staff to perform rvices for R5.				
	stated range of mot completed with per	irector of nursing (DON) tion services was to be sonal cares. The DON stated the exercises were not being ted.				
	services (RDCS) st restorative program hired a new compa to the residents. Th unaware R5's brace due to decreased n	egional director of clinical tated the facility did not have a n, however, they had recently ny to provide physical therapy he RDCS stated she was es were more difficult to apply novement. The RDCS stated be re-evaluated by physical				
	therapy assistant (F	p.m. the contracted physical PTA)-A stated R5 had not been cal therapy, therefore his ROM en assessed.				
		p.m. RN-E confirmed NA-C				
winnesota D	epartment of Health					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
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2 895	Continued From pa	ige 38	2 895				
	had provided the residents' restorative services in the past and stated NA-C would be the most knowledgeable staff member who could identify if a resident had a decline in ROM ability.						
	had severe cognitive which included Part and anxiety. The M extensive staff assi- living, total staff assi- functional limitation Daily Living CAA di- annual assessment R2's ROM abilities quarterly MDS date	lated 11/2/17, indicated R2 ve impairment and diagnoses kinson's disease, dementia IDS also indicated R2 required stance for all activities of daily sist for transfers, and had no is in ROM. The Activities of d not trigger at the time of the t, therefore an assessment of was not conducted. R2's ed 12/27/17, indicated R2 had is in bilateral upper and lower					
	dated 1/13/18, indic	f Functional Range of Motion cated R2 had bilateral in the upper and lower					
	to monitor and report provide physical the needed, and to more	ed 12/28/17, directed the staff ort changes in ROM ability, erapy referrals as order and as nitor/document/report any of immobility such as ng or worsening.					
		did not include a physical or by discharge summary.					
	R2 had received pa (PROM) to the bilat times per week, an five times a week.	ecord dated 1/2018, indicated assive range of motion teral lower extremities five d PROM to upper extremities , Restorative Record indicated					
	epartment of Health						

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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
NALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE	NUE WEST PO BOX 700		
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2 895	Continued From pa	age 39	2 895			
	extremities on 11 d documentation end blank from 2/15/18 2018, documentation On 3/21/18, at 11:3 assist R2 with char During the cares, F disconnected requi changed. While ch noted to be unable knees. NA-C state assigned to assist the middle of Febru reassigned to assist cares instead of co stated R2 used to k to about 50% full et longer being provid knees had become	led on 2/14/18. The record was - 2/28/18, and the March ion was blank. 0 a.m. NA-C was observed to nging an incontinent brief.				
	hands were held in her left shoulder an however, the right s than two inches an her arm at the elbo the ability to fully op manually opened R approximately a 90 hand opened to ap NA-C confirmed R2 extremities, however ROM ability had no stopped. NA-C sta	degree angle and the left proximately a 75 degree angle 2 had limitations in her upper er, stated R2's upper extremity t changed since the ROM had ated the staff were to complete ring morning cares, however,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00995			03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ALKER	REHABILITATION &		CHWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE COMPLE HE APPROPRIATE DATE	
2 895	Continued From pa	age 40	2 895			
		s, the staff did not have the OM exercises, as directed.				
		A stated R2 had not been cal therapy in order to es were needed.				
	R2's clinical record documentation rela in ROM exercises.	lacked any type of ited to R2's ability to participate	•			
	to be receive assist directed by the care completed the ROM therefore she would the facility who cou ROM had occurred licensed nurses has evaluating the ROM determine if the res services, evaluating for a change in a re stated the NAs wer with morning cares any pertinent charg charge nurse and t document the ROM administration reco Treatment Record related to range of provided. RN-E cor	is p.m. RN-E confirmed R2 was tance with PROM exercises as e plan. RN-E stated NA-C had M services in the past, d be the only staff member in ld truly identify if a change in l. RN-E confirmed none of the d been monitoring or M program in order to sidents were receiving the g their progress, or monitoring esidents' ROM ability. RN-E re to complete ROM exercises and were directed to report g in a residents' ability to the he nurses were directed to M on the treatment rds. Review of R2's electronic did not include documentation motion services having been onfirmed R2's record did not ram and verified R2 range of rextremities had declined.				
	had severe cognitive which included dem	S dated 3/9/18, indicated R23 /e impairment and diagnoses nentia, history of stroke and o speak). The MDS indicated				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00995	B. WING		03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NALKER	REHABILITATION &			NUE WEST PO BOX 700		
(X4) ID		ATEMENT OF DEFICIENCIES	R, MN 56484	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 895	Continued From pa	age 41	2 895			
	activities of daily liv 10/13/17, indicated	vive assistance with all ving. R23's annual MDS dated I R23 required total staff ctivities of daily living.				
	to have physical th therapy evaluate a physician. The ca to report signs and contractures formin	ted 7/19/17, directed the staff erapy and occupational nd treat R23 as directed by the re plan also directed the staff symptoms of immobility, or ng or worsening. The care the staff to assist R23 with				
	Summary dated 4/ extremity limitation therapist indicated R23 ROM with ma	ogress and Discharge 13/17, indicated R23 had lower s in ROM. The physical nursing staff was to provide nual stretches including s. The frequency of the indicated.				
	summary dated 4/* limitation in ROM in occupational thera	ogress and Discharge 14/17, indicated R23 had n the upper extremities. The pist indicated R23 was to cises however, the frequency s not identified.				
		ty's Restorative nursing not include a restorative or R23.				
	-	ectronic medication record did to assist with ROM.				
	had attempted to c the past, however, currently receiving	55 a.m. FM-B stated the facility omplete exercises with R23 in FM-B was unsure if R23 was services. FM-B stated he/she				
nesota De	epartment of Health ⁄I		6899	(19311	If continuatio	n sheet 42 of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		03/	03/27/2018	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE			
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 895	Continued From pa	ige 42	2 895				
	thought R23's feet a deformed.	and legs were becoming					
	On 3/21/18 at 3:10 p.m. PTA-A stated R23 had not been evaluated by physical therapy in order to determine if therapy or restorative services were needed.						
	observed to assist was in bed. While a pair of pants, R23 a his right leg. R23 p with his right hand a buttocks to pull his lift his buttocks off of have full range of n attempted to strike NA-C assisted R23 arm/shoulder move and was unable to	a.m. NA-B and NA-C were R23 with morning cares. R23 assisting R23 with donning a attempted kick at the NA's with proceeded to grab his pants and attempted to lift his pants up. R23 was unable to of the bed. R23 was noted to notion in his right arm as he out at the staff. As NA-B and to donne his shirt, R23's left ed approximately 3-5 inches fully extend. R23's elbows, re observed to be free from					
	R23 had never rece confirmed R23 had	C stated to her knowledge, eived ROM services and left sided limitation in ROM, nange in ROM abilities.					
	had limitations in R restorative program recently started with verified R23 had no	5 p.m. RN-E confirmed R23 OM and did not have a current n. RN-E stated that facility had h a new therapy provider and ot been evaluated for services eft sided limitations.					
	12/23/17, directed t	on Exercises policy dated the staff to exercise the d muscles. The policy also					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
ALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 895	Continued From pa	age 43	2 895				
	order, the staff wer physician to obtain addition the staff wer following in the residence - The date and time - The name of the p - The type of ROM - Whether the exer - How long the exer - How long the exer - If and how the residents of a procedures or any ability to participate - Any problems or a residents related to	person providing the exercise. exercises. cise was active of passive. rcise was conducted. sident participated in the changes in the resident's complaint made by the o the procedure. used the treatment and reason					
	The director of nurs develop, review, an procedures to ensu- motion services as designee could edu the systems. The D monitoring systems compliance.	THODS OF CORRECTION: sing (DON) or designee could nd /or revise policies and ure residents received range of directed. The DON or ucate all appropriate staff on DON or designee could develop s to ensure ongoing R CORRECTION: Twenty-one	0				
2 900	(21) days. MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			5/8/18	
	comprehensive res	sores. Based on the ident assessment, the director must coordinate the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		03/	03/27/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
VALKER	R REHABILITATION &		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	age 44	2 900				
	development of a r provides that:	nursing care plan which					
	without pressure s pressure sores unle condition demonstr authenticates, that B. a resident w receives necessar	to enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and who has pressure sores y treatment and services to revent infection, and prevent veloping.					
	by: Based on observat review, the facility f assessment, monit prevent the develop promote healing of of 6 residents (R5, who had current pr failure to adequate implement interven for R5 who develop	ent is not met as evidenced ion, interview and document failed to provide appropriate toring and interventions to pment of pressure ulcers and current pressure ulcers for 4 , R18, R2, R23) in the sample essure ulcers. The facility's ly assess, monitor and/or ations resulted in actual harm bed pressure ulcers while at R18 who had recurrent		corrected			
	Findings Include:						
	pressure ulcers an assistance with rep	t risk for the development of d did not receive timely positioning and developed two sulting in actual harm.					
	1/10/18, indicated I	mum Data Set (MDS) dated R5 had moderate cognitive agnoses included Parkinson's					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		03/	03/27/2018	
JAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	2112010	
		209 BIR(NUE WEST PO BOX 700			
VALKER	REHABILITATION &	WALKER	R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 45	2 900				
	indicated R5 requir members for bed n activities of daily liv R5 at risk for the de R5's admission MD as dependent upor	gia and depression. The MDS ed total assistance of two staff nobility, transfers and all ing. The MDS also identified evelopment of pressure ulcers. OS dated 9/1/17, identified R5 a staff for all activities of daily r the development of pressure					
	(CAA) dated 9/6/17 development of pre dependence upon bowel incontinence staff to complete w	er Care Area Assessment , identified R5 at risk for the essure ulcers due to staff for repositioning and . The assessment directed eekly skin assessments and to while assisting with personal					
	pressure ulcer deve	(a tool utilized to predict elopment) dated 11/22/17, for the development of					
	11/22/17, indicated blanchable" area or form did not identify had skin change/su	nce Observation form dated R5 displayed a "pink, ver boney prominences. The y which boney prominences isceptibility to pressure nor any for the staff to implement.	/				
		ed 8/28/17, directed the staff to sitioning at least every two					
	staff to apply a Der to the coccyx every	der dated 11/29/17, directed mFilm Thick Sacral Dressing r three days, and as needed. Ir r Summary also included an	1				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/	27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 46	2 900			
	directed the staff to	wound dated 10/3/17, which apply an Allevyn Dressing the left buttock wound and to days until healed.				
	Review of R5's Pro revealed the followi	gress Notes (nurses notes) ng information:				
	area was red, barrie - 2/3/18, redness to sacral area, barrier - 2/4/18, redness to sacral area, barrier	upper buttocks, coccyx and cream applied. upper buttocks, coccyx, and				
	applied and reposit provided. - 2/7/18, small exco	sacral areas. Barrier cream ioning every two hours priated area and redness to ccyx and sacral area, barrier				
	cream applied. - 2/12/18, scabbed	area to left buttocks and small				
	-2/16/18, scabbed a sacrum, barrier cre	crum, barrier cream applied. area to left buttocks and am applied. area to left buttocks and				
	buttocks measures cm. The left buttoc	ficial excoriated areas. Right 3.0 centimeters (cm) by 1.5 ks measured 1.0 cm by 0.7				
	stretchy dressing w - 2/24/18, dressing Presents as superfi	drocolloid thin dressing (a hich adheres to the skin.) changed, area is very dry. icial sheer area, small amount plied Duoderm (hydrocolloid)				
	dressing. - 2/26/18, friction st	near to bilateral upper buttocks	3			
	reposition every two					

TATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/27/2018	
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE. ZIP CODE		
	REHABILITATION &	HEALTHCARE CI 209 BIRC		NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORREC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 47	2 900			
	region, foam dress wound with an adh skin) applied. - 3/6/18, dry areas dressing applied. A Weekly Skin Rev R5 had "superficial and "excoriation on - 3/12/18, excoriate Tegaderm hydroco - 3/16/18, continues buttocks and sacra applied. - 3/20/18, excoriate	to upper buttocks and sacral ing (a foam pad to cover the esive edge to adhere to the to bilateral buttocks foam view dated 3/10/18, indicated open area on sacral areas" in the buttocks."				
	assessment of the measurements of t	ical record lacked a weekly wound which would include he wound, (length, width and wound and surrounding rrent interventions.				
		ical record lacked indication cian had been notified of the s.				
	revealed duplicative DermFilm dressing wound. The docum had initialed both d which indicated the	ctronic Treatment cord (ETAR), dated 3/18, e orders to apply Allevyn and s every three days to the same nentation revealed the nurses ressings every three days ey had both been applied to the h only one dressing was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00995			03/2	03/27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
VALKEF	REHABILITATION &		HWOOD AVEN , MN 56484	IUE WEST PO BOX 700		
(X4) ID	SUMMARY STA	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 48	2 900			
	in a wheelchair in the for supper. -At 5:05 p.m. regist evening meal. -At 5:20 p.m. RN-D turned the television -At 5:55 p.m. R5 re Nursing assistant (I assisted R5 to was change into a hosp repositioned. -At 6:06 p.m. NA-D in the chair and cor -At 7:50 p.m. NA-D room and transferre bed. R5's wheelcha redistribution seat of was covered with a hydrocolloid dressin the wound was dee - At 7:55 p.m. NA-A bed at 4:00 p.m. an repositioned for 3 h stated with only two doing the best they unable to provide a repositioning for all On 3/21/19, at 1:10 (DON) and the regis services (RDCS) st assistance with rep directed by the care medical record, the of the exact date R signs of breakdown	cushion in place. R5's coccyx n intact thin Tegaderm ng. The skin along the edge of p pink in color. A stated R5 was assisted out of id confirmed R5 was not iours and 50 minutes. NA-A b NAs on staff, the staff were could, however, they were ssistance with timely				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/	27/2018
ME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
ALKER	REHABILITATION &		HWOOD AVEN , MN 56484	NUE WEST PO BOX 700		
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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 49	2 900			
		as unable to determine the size d on the facility documentation.				
	Duoderm dressing removal of the dress newly opened area measured the first to be 1.0 cm x 0.3 of the lower left buttoo cm. In addition, un three deep red app blanchable areas. changed appearant observed it. RN-D new and the wound - At 2:10 p.m. the D The DON stated the R5's sacrum, the slintact. The DON co developed stage 2	D was observed to remove a from R5's sacrum. Upon asing, RN-D identified two s under the dressing. RN-D open area on the left buttocks cm. The second open area on cks measured 2.0 cm by 2.0 der the dressing there were roximately one inch non RN-D stated the wound had ce since the last time she had stated the open areas were I looked worse. DON observed R5's sacrum. e last time she had observed kin was dry and flaky but onfirmed R5 had newly ulcers (pressure ulcer in which in loss involving epidermis,				
	dermis, or both). R dressing over the u Review of R5's clin	N-D applied a Duoderm				
	related to the newly	v developed pressure ulcer's easurements from 3/21/18.				
	record and confirm pressure ulcer and any type of docume	a.m. RN-E reviewed R5's ed R5 had developed a the facility failed to complete entation or comprehensive d to the new pressure ulcers				
	identified on 3/21/1 treatment orders for the ETAR indicated	8. RN-E verified R5 had two r the same sacral wound and both dressings were being h only one dressing had been				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		- 03/27/2018	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
2 900	Continued From pa	ige 50	2 900			
	applied to the wound. RN-E also verified R5's care plan had not been followed as directed and R5 had not received wound care in accordance with the facility policy.					
	which had worsene complete a compre	a pressure related ulcer ad and the staff failed to hensive wound assessment to of current interventions, and care plan.				
	R18 had diagnoses impairment, stroke,	ecord dated 3/22/18, indicated which included mild cognitive hemiplegia, and hemiparesis, fatigue, venous insufficiency,				
	had severe cognitive extensive assist fro- toilet use, and was for transfers and hy the time of assesser pressure ulcer and (Stage 3- Full thick Subcutaneous fat in tendon or muscle a be present but does tissue loss. May inc tunneling) which me Ulcer treatments in	S dated 3/2/18, indicated R18 ve impairment, required om 2+ staff for bed mobility and totally dependent on 2+ staff vgiene. The MDS indicated at nent, R18 had one stage 2 two stage 3 pressure ulcers ness tissue loss. nay be visible but bone, are not exposed. Slough may s not obscure the depth of clude undermining or easured 2.0 x 6.0 x 0.4 cm. cluded pressure ulcer care, sing device for bed and				
	indicated R18 was ulcers, and had a h CAA further indicate mattress or seat cu	er CAA dated 8/22/17, at high risk for pressure istory of pressure ulcers. The ed R18 required a special ishion to reduce or relieve did not identify which type of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	R REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 51	2 900			
	special mattress ar required.	nd/or seat cushion R18				
	required extensive bathing, grooming a extensive assist of mechanical lift. The "has pressure ulcer pressure ulcer area potential impairmen fragile skin, immob pressure ulcers. Th to implement the for	nted on 3/22/18, indicated R18 assist of one staff for dressing and bed mobility, and two staff for transfers with a e care plan also indicated R18 rs development" related to as to the coccyx, and had a ht to skin integrity related to ility, weakness, and history of he care plan directed the staff ollowing interventions:	,			
	-report abnormalitie maceration and sig physician -identify/document eliminate/resolve w -use a draw sheet o resident.	nd dry, apply lotion on dry skin es, failure of skin to heal, in/symptoms of infection to the potential causal factors and there possible or lifting device to move the ents as ordered and to monitor				
	as needed -educate the reside causes of skin brea transfer/positioning taking care during a nutrition and freque -follow facility polici prevention/treatment	requirements, importance of ambulating/mobility, good ent repositioning. les for the nt of skin breakdown				
	-if the resident refu resident, interdiscip determine why and compliance. Docun	sed treatment, confer with the olinary team and family to try alternative methods to gair nent the alternative methods. ily/caregivers of any new skin				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	REHABILITATION &		CHWOOD AVE	NUE WEST PO BOX 700		
	REHABILITATION &	WALKEF	R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 52	2 900			
	if remains intact an dressing to treatme -monitor nutritional monitor intake and -monitor/document changes in skin sta healing, signs and s size, and stage. - obtain and monito -teach resident/fam positions for the pre and encourage sma -turn and reposition more often if neede -provide a pressure bed/chair, however of cushion to be us - use fracture bed p be on bedpan ten m report any redness -weekly skin observed documentation to in area of skin breakd type of tissue exuda Although the care pla developed pressure to reflect the pressure	if needed, every shift to ensure d adhering. Report loose ent nurse status. serve diet as ordered, record /report, as needed, any tus: appearance, color, wound symptoms of infection wound or lab work illy importance of changing evention of pressure ulcers all frequent position changes all frequent position changes all frequent position changes all frequent position changes all frequent gosition changes all frequent position changes all frequent position changes all frequent position changes all frequent position changes and or requested e relieving/reducing device on , does not identify which type ed. ban in bed. encourage R18 to ninutes, observe skin and or open areas to nurse vation. If open area, treatment nclude measurement of each lown's width, length, depth,				
	R18's Tissue Tolera 2/24/18, indicated F pressure ulcers with current or history of	required for R18's needs. ance Observation dated R18 was at high risk for h risk factors that included f pressure ulcers, history of t cooperative with positioning.				
	epartment of Health					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00005	B. WING		00/07/0040	
		00995			03/27/2018	
NAME OF I	PROVIDER OR SUPPLIER			NUE WEST PO BOX 700		
VALKEF	R REHABILITATION &		R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 900	Continued From pa	age 53	2 900			
	prominences was p sitting for one and a evaluation also ide position after 1/2 he the skin over bony blanchable. The ev	cated skin over bony bink and blanchable after two hour time frames. The ntified when R18 was in a lying our, one hour, and two hours prominences was pink and valuation did not identify where e and did not identify a dule.				
	R18's physician or	ders included:				
	(start date 2/13/17) -wound evaluation Monday per MD or -Change Tegaderm moist wound bed) t days in the morning prep to coccyx befo prevent skin tears. 3/20/18) -Monitor Tegaderm upper buttocks eve is in place, dressing Dressing to remain 9/30/17) -Comfort foam (for with border dressin wounds change ev date 3/21/18)	skin assessment on Mondays on left upper buttock every der (start date 2/20/17) n hydrocolloid (maintains a thin 4x4 dressing every three g and as needed; apply skin ore applying new dressing to (start date 8/23/17, stop date hydrocolloid thin dressing to ery shift to make sure dressing g is dry and intact every shift. on until healed. (start date medium to heavy drainage) g 4x4 to sacral and buttock ery 3 days until healed (start wheelchair (start date 3/20/18)				
	(PN) reviewed form lacked completed of and consistency of ascertain locations	ws (WSR) and progress notes n 1/1/18, through 3/20/18, comprehensive evaluations documentation in order to , worsening, and or healing further lacked evidence of device efficacy				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		03/	03/27/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
NALKEF	R REHABILITATION &	HEALTHCARE CI 209 BIRG		NUE WEST PO BOX 700			
(X4) ID	SI IMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG	(EACH DEFICIENC)	(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	ge 54	2 900				
	mid coccyx slit, res and a patch was ap orders. -WSR dated 1/8/18 maceration, applied coccyx, had a smal -PN note dated 1/14 dressing placed to superficial, still very buttock 1.0 cm x 1. areas on right butto -WSR dated 1/15/1 maceration on cocc 1.0 centimeter (cm wound. Applied dre record lacked evide evaluation or ongoi -WSR dated 1/22/1 fold, skin wet and w open area. On the wounds. Proximal r measures 0.5 x 0.5 applied Mepilex dre -PN dated 1/23/18, contacted related to coccyx not healing incontinence. MD o indwelling catheter -WSR dated 1/29/1 coccyx 1.0 cm x 0.6 on coccyx, noted m applied after coccym monitor. -Corresponding PN coccyx was healing placement and to re for full description.	 8, Continues to have cyx, has on upper right buttock open area. Red around ssing per MD orders. The ence of any further wound ng treatment. 8, Has maceration in gluteal white in color. Has 2.0 x 0.3 cm right buttock has 2 open neasures 1.0 x 0.9 cm. Distal No drainage. Cleansed and essing. indicated the MD was o open areas on buttocks and related to urinary ordered placement of an 					

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/	27/2018
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 55	2 900			
	cm by 0.7 cm with a questionable tunnel bed. -PN dated 2/3/18 in appeared smaller, a No odor, redness, o -WSR dated 2/5/18 cm depth. Moisture wound bed. Derma changed every 3 da -PN dated 2/6/18, M measurements of o -WSR dated 2/12/11 left open to air for o Upper left coccyx th 3.0 x 1.0 cm, no de and upper bilateral 0.02 cm with brown attached around so -WSR dated 2/19/1 area on coccyx. No buttock small pinpo Not open but surror -WSR dated 2/26/1 2.0 cm by 0.6 mm areas of eschar 0.5 yellow devitalized th thick and adherent present. Scant amo odor present on dra wound. Other areas measure 2.0 cm x -Corresponding PN director of nursing notified of the chan -PN dated 3/2/18, i completed related to noted on coccyx 2.	 8, coccyx 1.0 x 1.0 cm with 0.4 associated. Able to visualize illevyn thin to be applied and ays. MD made aware of the coccyx wound. 18, Coccyx very macerated and one hour and turned to scabs. hin pink skin area measures epth superficial. Rest of coccyx buttocks have 0.04 to 0.03 to n dry scabs. With dry skin cabbed areas. 18, coccyx 1.0 x 0.4 cm purple of open at this time and left bint 0.1 by 0.1 cm purple area. 18, center of coccyx measures wound bed depth 0.4 mm, 5 mm and slough (defined as issue, that can be stringy or on the tissue bed) was bunt brown drainage with slight essing and skin around the s on lower right buttock (DON), MD, and family were 				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED	
		00995	B. WING	8. WING		27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ALKER	R REHABILITATION &	HEALTHCARE C	CHWOOD AVEN R, MN 56484	UE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 900	Continued From pa	ige 56	2 900			
	coccyx changed ev Offload side to side note indicated the o updated and an air 3/2/18. The note all historically refused an area to allow rep repositioning and s -WSR dated 3/5/18 3, no drainage app 0.2 x 0.2 cm scabb reddened. Left butt area, surrounding s resident non-compl repositioning from s cleansed and applie -WSR dated 3/12/1 circular, 0.03 mm d purple, other areas -PN dated 3/16/18, painful area to right some type of boil o ulcer. Foam dressin be notified.	 a, 2.0 cm x 1 cm healing stage b, 2.0 cm x 1 cm healing stage cears macerated. Left buttock ed area, skin around scab oock 2.0 cm x 2 cm scabbed skin white. Also included liant with turning and side to side. Larger areas ed Dermallevyn. a, coccyx area 0.5 mm lepth. Wound bed is deep that were open healed. included 2.0 x 2.0 red raised, t ischium. Question if may be r beginning of a pressure ng was applied, and MD would 				
	Wound bed 100% g cleansed and Derm 1.0 cm x 1.0 cm pro (Suspected deep to	8, coccyx 1.5 x 1.0 cm. granulation tissue. Wound nallevyn applied. Right buttock esents as deep tissue injury ssue injury-purple or maroon scolored intact skin or blood				
	filled blister due to tissue from pressur be preceded by tiss boggy, warmer or c	damage of underlying soft re and/or shear. The area may sue that is painful, firm, mush, cooler as compared to adjacent ay include a thin blister over a				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY PLETED
		00995	B. WING		03/2	27/2018
IAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
VALKER	REHABILITATION &			NUE WEST PO BOX 700		
(X4) ID	SUMMARY STA		MN 56484	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLET
2 900	Continued From pa	age 57	2 900			
	Left buttock has two wounds- each measuring 1.0 x 0.2 cm. Present as possible skin tears. Cleansed and applied Dermallevyn.					
	her room, seated in cushion in the when standard pommel of seating position and is made of dense for sliding out of the wh the bed was standa R18 stated she had bottom, had them f experienced discor R18 stated when st dressings she experi indicated pain med to the dressing cha wanted an air mattur received one. R18 wheelchair cushion R18 further stated st	nfort when she sat too long. taff changed her wound erienced discomfort, however, ication was administered prior inges. R18 stated she had ress on her bed but had never stated did not think her had been changed/replaced. staff did not always reposition they could probably offer to				
	transfer R18 from h full body mechanica wounds on her bott bottom since 3/16/ told her R18 had ac breakdown. NA-B p exposed two hydro over the left buttoch	' p.m. NA-B was observed to her wheelchair into bed using a al lift. NA-B confirmed R18 had tom but had not seen R18's 18, and stated somebody had dditional areas of skin bulled down R18's pants, which colloid dressings positioned k and sacral/coccyx region, uttock. NA-B stated the wound y since last week.				
nesota De		cal doctor (MD)-B and health UC) entered R18's room.				

ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING	B. WING		27/2018
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVEN R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	MD-B asked R18 if from the sores, to v some discomfort. A dressings, MD-B re type of dressing be assessed the woun -upper coccyx sacr stage 3) -left buttock open s the open wound wa and because of tha -left buttock above small superficial arc probably caused fro bandage and were related. -Right buttock over purple area with su stated the purple ar (non-viable tissue of and would be a stag -small stage 2 on th MD-B stated the sa improvement since catheter. MD-B ask been going to which well. MD-B reinforc to R18. R18 agreeo further evaluation. I cushion was firm an enough support and something more pro- stated R18 should I her bed in order to	ige 58 she had experienced pain which R18 responded she had as MD-B removed the tacky marked she did not like this cause it rips the skin. MD-B ds and verified the following: al region stage 2, (healing tage 2; the other wound below as superficial and "covered" t was hard to stage. the stage 2 ulcer were two eas and stated those were om removing the adhesive not considered pressure ischium a small raised dark rrounding redness. MD-B rea was necrotic tissue due to reduced blood supply) ge 2 when it opened. he inner right buttock coral wound had shown the insertion of an indwelling ted R18 how repositioning had in R18 responded, not very ed importance of repositioning d to go to the wound clinic for MD-B verified the wheelchair ind flat and did not provide d should be changed to essure relieving. MD-B also have had an air mattress on provide more pressure relief d. HUC stated nursing staff			. ,	

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/27/2018	
		00995	B. WING			
	PROVIDER OR SUPPLIER		DRESS, CITY, ST			21/2010
		209 BIRC		NUE WEST PO BOX 700		
VALKE	R REHABILITATION &		, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 59	2 900			
	pretty set routine an repositioned every but often refused. N repositioning, staff of refusing such as stated she did not t because the reside repositioned 10-30 R18's mattress and changed and had a she currently used. -At 8:48 a.m. RN-D designated RN to p assessments, there whichever nurse wa RN-D stated skin a weekly, wound doc include measureme pressure ulcer the stage of the ulcer. If assessing nurse ne causal factors of th implement appropri- stated if the pressu- the interventions sh effectiveness and t and surfaces shoul effectiveness. -Continuous observ 1:44 p.m. revealed -At 11:30 a.m. R18 wheelchair, watchin -At 12:04 p.m. NA- room for lunch	e stated there was no berform pressure ulcer/wound efore were completed by as assigned to work that day. ssessments were performed umentation should always ents, and if the wound was a nurse should indicate the RN-D further stated the eeded to determine possible to breakdown and evaluate and iate interventions. RN-D ire wounds were not healing, hould be reassessed for he pressure relieving devices id also be assessed for vation from 11:30 a.m. until the following: was in her room, seated in the				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/	27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
VALKE	R REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 60	2 900			
	not repositioned wh -At 12:49 p.m. RN- Observations were comprehensive. RN should have been of measurements incl then staged, a com drainage, odor, cur toward healing, and reassessment of in new interventions, a RN-E stated the fac inconsistent with th difficult to ascertain with the skin. RN-E maintenance direct the bed on 3/2/18, a implemented that s -At 12:54 p.m. RN- verified the mattress mattress she had re RN-E confirmed R2 foam mattress whic facility used, and w pressure ulcer/pres- indicated the only of was it had the edge -At 1:44 p.m. R18 rf wheelchair. R18 sta in the wheelchair un over at 2:00 p.m. R	N-E stated all the evaluations completed to identify: luding depth, if pressure ulcer aplete description of the wound rent treatment, progress d if worsening then terventions, implementation of and notification to physician. cility nurses were very eir documentation and it was n exactly what was going on confirmed she had asked the tor to put the air mattress on and thought it had been ame day. E observed R18's bed and as on R18's bed was not the air equested to be put on the bed. 18's mattress was a standard ch all the residents in the as not provided based on her asure relief needs. RN-E lifference on R18's mattress				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		0.3/	27/2018
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE. ZIP CODE	03/	2772010
	REHABILITATION &	HEALTHCARE CI 209 BIRC	HWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	WALKER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 61 e specific order documentation	2 900			
		lace the air mattress on the				
	quarterly interdiscip identified no behavi cares. Additionally, current on 3/22/18,	tified refusal of cares, the blinary review dated 12/30/17, iors which included refusal of the care plan printed as failed to identify refusal of ed interventions related to				
	had severe cognitiv which included Parl and anxiety. The a required total assis	lated 11/2/17, indicated R2 ve impairment and diagnoses kinson's disease, dementia ssessment indicated R2 tance with bed mobility and at risk for the development of				
	R2 at risk for the de due to the inability t	r CAA dated 11/3/17, identified evelopment of pressure ulcers to reposition herself. The CAA ovide a redistribution cushion in bed.				
	10/31/17, indicated completed and ider development of pre clinical record did n Braden Scale. The not developed redd observation time. T	nce Observation form dated a Braden Scale had been ntified R2 at high risk for the essure ulcers, however, R2's not contain a copy of the observation indicated R2 had lened areas during the The observation tool did not cy of repositioning needs for				
	R2's care plan date	ed 12/28/17, identified R2 at				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		03/	03/27/2018	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
		209 BIRC		NUE WEST PO BOX 700			
	REHABILITATION &	HEALTHCARE CI WALKER	R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE ⁻ DATE	
2 900	Continued From pa	nge 62	2 900				
	risk for the development of pressure ulcers and directed the staff to assist R2 with a repositioning every two hours.						
	7:05 a.m. to 10:00 be assisted with rep - At 7:05 a.m. R2 w wheelchair in her ro - At 7:37 a.m. the H room to the dining r - At 7:41 a.m. the H with breakfast. - At 8:07 a.m. R2 h HUC wheeled R2 o - At 8:12 a.m. R2 w - At 8:57 a.m. R2 w room by the activity - At 9:53 a.m. NA-E bed at 6:30 a.m. ar assist/reposition he - At 10:00 a.m. NA- and assisted R2 to to the bed via a full pressure redistribut	vas observed seated in a bom. HUC wheeled R2 from her room. HUC served and assisted R2 ad finished the meal. The but of the dining room. vas wheeled back to her room. vas wheeled into the activity v director. B stated R2 was assisted out of ad she had not had time to	F				
	changed R2's incor pink and intact. -At 10:05 a.m. NA-I	ntinence brief. R2's skin was B confirmed R2 had last been itioning at 6:30 a.m. a total of					
		p.m. RN-E confirmed R2 was repositioning every two hours care plan.					
	had severe cognitiv	S dated 3/9/18, indicated R23 ve impairment and diagnoses nentia, history of stroke and					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
ALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVEN R, MN 56484	NUE WEST PO BOX 700			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 63	2 900				
	R23 required exten mobility and transfe development of pre MDS dated 10/13/1 totally dependent u transfers and at rist pressure ulcer. R23's Pressure Ulc identified R23 at rist pressure ulcers and pressure reducing to assist R23 with offle needed. R23's Braden Scale Sore Risk dated 3/9	e speak). The MDS indicated sive assistance with all bed ers and was at risk for the essure ulcers. R23's annual 17, also identified R23 as being pon staff for bed mobility, k for the development of cer CAA dated 10/9/17, sk for the development of d directed the staff to utilize a mattress, chair cushion, and to oading every two hours and as e for Prediction of Pressure 9/18, identified R23 at ne development of pressure	0				
		ce Observation Tool dated 23 did not develop reddened ırs in one position.					
		ted 7/19/17, directed staff to oning every two hours.					
	7:13 a.m. to 10:07 receive assistance - At 7:13 a.m. NA-E transfer R23 from t body mechanical lif	and NA-C were observed to bed to a wheelchair via a full					
	- At 8:48 a.m. R23 breakfast meal.	was assisted with the was wheeled to the activity					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00995			03/	03/27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE
2 900	Continued From pa	age 64	2 900			
	- At 9:35 a.m. R23 room to the nurses	was wheeled from the activity				
		3 was wheeled to his room.				
		-B and NA-C were observed				
		m the wheelchair to the bed via	I I			
	a full body mechan	ical lift. A pressure on was noted on R23's				
		23's skin was clear and intact.				
		-B and NA-C confirmed R23				
		ssistance with repositioning				
	since 7:13 a.m. a to earlier.	otal of 2 hours and 50 minutes				
		35 a.m. RN-B stated R23 was ce with repositioning every two				
	hours as directed b					
		e Management Minnesota				
		procedure, Pressure Ulcer lated 12/23/17, indicated the				
	following:					
		e usually formed when a				
		in the same position for an time causing increased				
	pressure or decrea					
		are not treated when				
	discovered, they ca	an become larger, painful, and				
		e often made worse by				
		heat, moisture, irritating				
		resident's skin (feces, urine,				
		lecline in nutrition, and cute illness or decline in the				
		and/or mental condition				
	-pressure ulcers ar	e a serious skin condition for				
	the resident					
		nd document the condition of				
		per facility wound and skin ny signs and symptoms of				
	irritation or breakdo					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/	27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 65	2 900			
		essed for the presence of e ulcers on a weekly basis or ndicated.				
	Region policy and p Treatment dated 12 guidelines and stra stage III pressure u consistent assess implementation of a monitoring for effica	e Management Minnesota procedure, Pressure Ulcer 2/23/17, included general tegies for stage I, stage II, and lcers which directed nent and documentation, appropriate interventions, and acy of interventions based on				
	The director of nurs develop, review, an procedures to ensu- ulcers receive appr designee could edu DON or designee of systems to ensure	THODS OF CORRECTION: sing (DON) or designee could ad /or revise policies and ure resident with pressure copriate cares. The DON or ucate all appropriate staff. The could develop monitoring ongoing compliance and as to the quality assurance				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	;			
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			5/8/18
	have a continuous management to rec unnecessary use o	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that:				

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Minnesc	ta Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00995	B. WING		03/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AV	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	 A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trace much normal bladd This MN Requirement by: Based on observation review, the facility for comprehensive blat the continued need 1 of 2 residents (Resident of catheter. Findings include: R5's quarterly Minin 1/10/18, indicated F impairment and dia disease, quadripleg indicated R5 require members for bed ma activities of daily liv R5 utilized an indwo R5's Urinary Incont Catheter Care Area 	ho enters a nursing home ag catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder the treatment and services to at infections and to restore as ler function as possible. ent is not met as evidenced ion, interview and document ailed to complete a dder assessment to determine for an indwelling catheter for 5) who utilized an indwelling mum Data Set (MDS) dated R5 had moderate cognitive ignoses included Parkinson's gia and depression. The MDS ed total assistance of two staff hobility, transfers and all ing. The MDS also indicated elling urinary catheter. PS dated 9/1/17, identified R5 a staff for all activities of daily a of the catheter. inence and Indwelling a Assessment (CAA) dated		corrected		
	catheter. The CAA	5 utilized an indwelling Foley A did not include a				
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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		03/2	03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
WALKER	REHABILITATION &		HWOOD AVE	NUE WEST PO BOX 700			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID			(X5) COMPLET	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE	
2 910	Continued From pa	age 67	2 910				
	comprehensive assessment of the catheter.						
	indicated R5 had u unable to be treated surgically. The ass indwelling catheter was not comprehen the catheter was pl	ssment Form dated 11/22/17, rinary retention which was d or corrected medically or sessment indicated R5 had an . However, the assessment nsive as it did not identify when aced, attempts to remove the afection history or past bladder					
	indwelling catheter	ed 9/6/17, indicated R5 had an and directed the staff how to er and to monitor for signs and ion.					
	R5 had been starte for 7 days for the tr	er dated 11/15/17, indicated ed on Macrobid (an antibiotic) reatment of a urinary tract cal record did not contain a sis.					
	by nursing assistan was observed to ha	5 p.m. R5 was assisted to bed hts (NA)-B and NA-F. NA-B ang R5's catheter drainage bag bed frame. NA-B then er drainage bag.	9				
	(DON) reviewed R8 had a diagnosis of admission to the fa the catheter. The I treated for a urinary facility, however, th) p.m. the director of nurses 5's record and indicated R5 urinary retention upon icility and R5 was admitted with DON confirmed R5 had been y tract infection while at the ise clinical record did not been evaluated for medical	n				
	attempted to be rer	er or if the catheter had been moved. The DON confirmed completed a comprehensive					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING	B. WING		27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ige 68	2 910			
	assessment for the indwelling catheter.	continued need of the				
	A policy related to in requested and non-	ndwelling catheters was e was provided.				
	The director of nurs develop, review, an procedures to ensu received appropriat or designee could e The DON or design systems to ensure report those results	THODS OF CORRECTION: sing (DON) or designee could id /or revise policies and irre residents with catheters te care and services. The DON educate all appropriate staff. nee could develop monitoring ongoing compliance and to the quality assurance er recommendations.	I			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 945	MN Rule 4658.053 Eating - Nursing Pe	0 Subp. 1 Assistance with ersonnel	2 945			5/8/18
	personnel must det served diets as pre help in eating must receipt of the meals unhurried and in a enhances each res Adaptive self-help of contribute to the res eating. Food and fl be observed and do reported to the nurs resident's care duri observation of a de	g personnel. Nursing termine that residents are scribed. Residents needing be promptly assisted upon s and the assistance must be manner that maintains or ident's dignity and respect. devices must be provided to sident's independence in luid intake of residents must eviations from normal se responsible for the ng the work period the viation was made. Persistent ns must be reported to the				

Minnesc	ta Department of He	alth			T OT WIT	"INOVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		00995	B. WING		03/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE C	CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 945	Continued From pa	-	2 945			
	attending physician	i. ent is not met as evidenced				
	by: Based on observati review, the facility fa equipment to prome for 1 of 1 residents	on, interview and document ailed to provide adaptive ote independence with eating (R23) reviewed for nutrition difficulty eating and drinking.		corrected		
	Findings include:					
	3/9/18, identified R2 impairments and di history of stroke an The MDS indicated	imum Data Set (MDS) dated 23 with severe cognitive agnoses including dementia, d aphasia (inability to speak). R23 required extensive activities of daily living				
		dated 10/13/17, also identified tensive assistance with				
	(CAA) dated 10/20/ disruptive behaviors The CAA consisted	atus Care Area Assessment 17, indicated R23 displayed s and threw food during meals of check marks for the no compressive assessment needs.				
		Data V2.1 form dated R23 did not require adaptive neals.				
Minnoacta D		ted 1/20/18, indicated R23				
STATE FOR	epartment of Health M		6899	RI9311	fcontinuation	sheet 70 of 136

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE			
ALKER	REHABILITATION &		HWOOD AVE	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 945	Continued From pa	age 70	2 945				
		e guard for meals to ensure It greater than or equal to 75%					
	stated R23 seemed visited the facility. R23 a covered cup	47 a.m. family member (FM)-B d to be very thirsty when FM-B FM-B stated she had brought to use in his room but was were allowing R23 to use the					
	the dining room in a R23's wheelchair w was positioned per	05 p.m. R23 was wheeled into a tilt and space wheelchair. vas in a reclined position. R23 pendicular to the table as his o high to fit under the table.					
	thickened juice and glass. R23 was ob his shirt as he was lips without spilling. - At 12:10 p.m. R23 glass, attempt to dr - At 12:12 p.m. fam unidentified staff m	3 reached for a glass of a attempted to drink from the served to spill the juice onto not able to get the glass to his 3 continued to pick up his rink and spilled onto his shirt. hily member (FM)-A asked an ember if R23 was able to feed ed "I have never seen him try					
	spilled the juice ont - At 12:17 p.m. nur R23 the noon meal and fruit. R23's pla equipped with a pla feed R23 with the n - At 12:32 p.m. R23 of the meal with the	sing assistant (NA)-C served consisting of ham, potatoes ate was not observed to be ate guard as NA-C began to neal. 3 had eaten approximately 1/3 e assistance of NA-C. R23					
		endently pick up his glass, causing the liquid to spill onto					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/	27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ALKER	R REHABILITATION &		HWOOD AVEI A, MN 56484	NUE WEST PO BOX 700		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
ŘÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
2 945	Continued From pa	age 71	2 945			
	the dining room. R sloppy Joe (sandwi beans and fruit. R sandwich in his har NA-B attempted to items but R23 refus - At 12:57 a.m. R23 room . R23 had ea bites of the other m	3 was assisted out of the dining aten 100% of the sandwich and neal items. R23's shirt was	1			
	 observed to have spilled juice on it. At 5:00 p.m. R23 was observed to be seated perpendicular to the dining room. A glass of thickened juice was observed on the table, which R23 picked up and began drinking. R23's wheelchair was in a semi-reclined position as he began to take sips from the glass. R23 was observed to spill a small portion of the juice onto his shirt. At 5:06 p.m. NA-D served R23 a meal consisting of tuna noodle casserole, peas and a bun. R23's plate was not observed to be equipped with a plate guard. NA-D was observed to turn R23's wheelchair so he was able to face the meal and repositioned the wheelchair into an upright position. At 5:08 p.m. R23 picked up his spoon and began to feed himself. At 5:13 p.m. R23 attempted to drink a glass of 					
	floor. Once the gla eat the meal with h to have a significan the food) spill onto while eating. NA-D R23 with eating the	down himself and onto the ss hit the floor, R23 began to is fingers. R23 was observed it amount (greater than 1/2 of himself, the table and the floor was not observed to assist meal. tered nurse (RN)-E asked				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		02/07/0040	
					03/27/2018	
IAME OF P	ROVIDER OR SUPPLIER			NUE WEST PO BOX 700		
VALKER	REHABILITATION &	HEALTHCARE C	, MN 56484	NUE WEST FU BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLET	
2 945	Continued From pa	ige 72	2 945			
	NA-D if she could a NA-D directed RN- RN-E that if the foo a history of striking to R23 and realized to sit properly. RN- and raised the level lever on the table p positioned under the without over extend - At 5:30 p.m. R23 25% of of his meal spillage noted on the R23 was not recept assist him with the On 3/21/18, at 12:1 the dining room. N R23's plate was no guard. NA-B was of feed him the meal. - At 12:29 p.m. the any type of adaptive was identified on the Review of R23's did type of adaptive eq had an order for a p was discontinued a at the time, R23 was himself. The DM so documented the dis guard. The DM con himself the past few provided. The DM a utilized covered cup covered up in his ro members. The DM	assist in the dining room. E to assist R23 and warned d was spilled on R23, he had out at the staff. RN-E sat nex the table was too low for R23 E then reached under the table I of the table by cranking a edestal stand. R23 was then e table to reach the meal ling his arms. had finished approximately with a significant amount of he floor, R23 and the table. tive to RN-E's attempts to				
	to be evaluated for	additional adaptive equipment				
	at meals.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		03/	27/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 945	Continued From pa	ge 73	2 945			
	Review of R23's clin documentation rela the plate guard.	nical record lacked ted to the discontinuation of				
	stated she was una equipment R23 was her knowledge, no s member had reque the use of adaptive she would review R information related	to her knowledge, no				
	A policy related to a requested and not p	idaptive meal equipment was provided.				
	The director of nurs develop, review, an procedures to ensu appropriate adaptiv DON or designee c appropriate staff. The develop monitoring	THODS OF CORRECTION: sing (DON) or designee could d /or revise policies and re all residents received the e equipment at meals. The ould could educate all he DON or designee could systems to ensure ongoing port the results to the quality ee for further				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one	,			
21225	MN Rule 4658.0700 Duties Develop res) Subp. 2 A Medical Director; care P&P	21225			5/8/18
		ne medical director, in administrator and the				

Minnesc	ta Department of He	ealth			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
		209 BIRC	HWOOD AVI	ENUE WEST PO BOX 700	
WALKE	R REHABILITATION &	HEALTHCARE C WALKER	, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
21225	Continued From pa	ige 74	21225		
	for: A. the developmen	services, must be responsible at of resident care policies and a to be approved by the			
	by: Based on interview medical director fai and procedures had implemented to ens This deficient pract	ent is not met as evidenced and document review, the led to ensure facility policies d been developed and sure quality of resident care. ice had the potential to affect o resided in the facility.		corrected	
	Findings include:				
tion of the second s	on 3/26/18, at 11:43 she made rounds a once a week, she v any time, and atten meetings at least e stated she was invo implementing qualit staffing, and stated the facility were rela- both front line staff MD stated she was outbreak that had o not aware staff was protective equipme spread of infection was not aware if the control policies dev MD stated falls wer meeting, however v	director (MD) was interviewed a.m. during which she stated at the facility a minimum of vas available by telephone at ded the quality assurance very three months. The MD olved with developing and ty action plans for sufficient a large portion of the issues in ated to the rapid turn over in and management staff. The very involved in the influenza occurred in January, but was a not wearing proper personal nt (PPE) to minimize the to other residents. The MD e facility had proper infection reloped and implemented. The re reviewed at every QAPI was not aware if the facility had procedures to follow so fall ed.			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00995	B. WING		03/27/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		03/	21/2010
	REHABILITATION &			NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21225	Continued From pa	age 75	21225			
	control, abuse prof mechanical lifts, pr medication monitor transfer & discharg	acility policies for infection hibition, falls, use of essure ulcers, psychotropic ring, resident rights, admission je, and dignity, revealed none idicating approval by the				
	interviewed on 3/26 confirmed the med	or of clinical services was 6/18, at 1:26 p.m. and ical director had not reviewed of the aforementioned policies.				
	The administrator of review, and /or review, and /or review, ensure the medica review, developme facility practices. The could develop mono ongoing compliance	THODS OF CORRECTION: or designee could develop, ise policies and procedures to I director was active in the nt and implementation of he administrator or designee itoring systems to ensure the and report the results to the committee for further				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			5/8/18
	home must establis	on control program. A nursing sh and maintain an infection ssigned to provide a safe and ent.				
	This MN Requirem	ent is not met as evidenced				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/2	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
NALKEF	REHABILITATION &	HEALTHCARE C		ENUE WEST PO BOX 700		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE
21375	Continued From pa	ige 76	21375			
	review, the facility f an ongoing infectio to identify potential failure resulted in a to an influenza A ou 1/18/2018, in which initiated for 4 reside R6) who tested pos additional residents R227, and R2) who symptoms of influe procedures related been developed an had the potential to in the facility at the addition, the facility precautions were infe required contact pro- facility failed to ens was completed for R2) observed to read	ion, interview and document ailed to develop and maintain n control surveillance program infectious outbreaks. This n immediate jeopardy (IJ) due utbreak from 1/5/2018 - a droplet precautions were not ents (R12, R124, R125, and sitive for influenza A, and for 8 s (R21, R10, R9, R4, R1, R8, o displayed signs and nza. In addition, policies and to infection control had not d implemented. This practice affect all 23 residents residing time of the outbreak. In failed to ensure contact nitiated for 2 of 2 residents (R5 ected with organisms which ecautions. Additionally, the ure appropriate hand hygiene 3 of 8 residents (R8, R18 and ceive medications. This tential to affect all 23 residents ity.	,	corrected		
	Findings include:	· · · · · · · · · · · · · · · · · · ·				
	the lack of initiation on 1/5/18, when R1 influenza A and the standard and droph transmission of influ Three additional re- tested positive for in developed flu like shighly contagious d	fection control practices and of isolation precautions begar 2 was diagnosed with facility failed to initiate et precautions to prevent the uenza to other residents. sidents (R125, R124 and R6) nfluenza and 8 other residents symptoms. Influenza A is a lisease which is spread s. The administrator and the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
VALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ige 77	21375			
	3/23/18, at 4:05 p.m removed on 3/27/14 non-compliance real level of F, which ind failure which had th residents residing in According to the Ce (CDC) an outbreak care facility is ident testing positive for influenza are encou- others and standar to be initiated. (refe people who get infli- days to less than tw develop complication result of the flu, sor life-threatening and bronchitis, sinus an of complications fro- chronic health prob On 3/23/18, at 8:00 clinical services (RI have a nurse identii infection control pre- all infection control pre- all infection control were to be directed - At 8:30 a.m. the a were interviewed re- practices of the fac assumed the respon	enters for Disease Control of influenza in a long term ified as two or more residents influenza. Individuals with uraged not to mingle with d and droplet precautions are erence: www.CDC.gov). Most uenza will recover in a few vo weeks, but some people wil ons (such as pneumonia) as a me of which can be I result in death. Pneumonia, id ear infections are examples om flu. The flu can make				
	outbreak in Januar completed by the fo	ate was for an influenza y 2018, which had been ormer DON. The DON stated the infection control				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 78	21375			
	months of January, after having review identifying there we treated with antibio logs did not include illnesses which we The Influenza-like I on 1/5/18, indicated Influenza A on 1/5/ additional residents also tested positive 1/5/18 and 1/15/18 were identified as o (including but not li	e week of 3/12/18, for the , February and March 2018, ed resident records and ere residents who had been tics. The DON confirmed the e the tracking or trending of re not treated with antibiotics. Ilness Line List form initiated d R12 had tested positive for 18. The form identified three s (R125, R124, and R6) who e for Influenza A between . Eight additional residents lisplaying flu like symptoms mited to fever, cough, muscle chills) during the identified				
	the Minnesota Dep dated 9/21/16, influ predominately by la are expelled from t coughing or sneezi usually did not rem close contact (usua required for transm 24 hours prior to th were usually contag onset of illness. Th influenza was ident website directed th outbreak by the imp droplet precautions suspected or confir precautions were to days after illness of	cility information printed off of artment of Health website enza transmission occurred arge respiratory droplets that he respiratory tract during ng. The droplet particles ain suspended in the air, and ally less then three feet) was ission. Infectiousness begins e onset of the illness. Adults gious until five days after the he incubation period for ified as one to four days. The e facility to control an influenza olementation of standard and a for all residents with med influenza. The o remain in place for seven nset or until 24 hours after the and respiratory symptoms,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/2	27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
VALKEF	R REHABILITATION &		CHWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 79	21375			
	Examples of Standard Precautions were identified as:					
	respiratory secretio - change gloves an encounter - perform hand hyg and after removing Examples of Drople as: - private rooms if po - cohorting ill reside unavailable	d gowns after each resident iene before wearing gloves gloves et Precautions were identified				
	room - have the resident or transportation is	wear a facemask if movement necessary.				
	Region Influenza, F Seasonal (influenza directed the staff to	hcare Management Minnesota Prevention and Control of a) policy dated 12/27/17, initiate standard and droplet esidents identified with				
	indicated R12 had i limited to supervisio living, did not walk, locomotion on and	imum Data Set dated 1/26/18, ntact cognition, required on/set up for activities of daily and was independent with off the unit. The MDS also offered but declined the vaccine.				
	R12 had been sent	er Sheet indicated on 1/8/18, to the emergency room on creased temperature, cough,				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/2	27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKEP	R REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 80	21375			
	with influenza A and anti-viral medication R12's clinical recor- R12 to remain in hi is no evidence drop implemented. R124's admission I severely impaired of assistance of one to daily living, and had vaccine prior to adr R124's Progress N indicated at 7:20 a. temperature, non p noted and was treat no further wheezing stated she felt bette before. -A PN dated 1/8/18 continued with a low wheezing, and a no remained in her root spread of infection. -A PN dated 1/8/18 had vomited, was r to touch. Temp 101 cough, increased w saturation was at 8 emergency room for -A PN dated 1/8/18 was admitted to the influenza A and pre Although R124's clit to her room, the recor-	, at 10:51 p.m. indicated R124 estless and her skin was warm .6, has loose productive /heezing, and oxygen 0%. R124 was sent to the or an evaluation. , at 2:52 a.m. indicated R124 e hospital for treatment of				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED			
		00995	B. WING		03/	27/2018			
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE					
WALKER REHABILITATION & HEALTHCARE CI WALKER, MN 56484									
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
21375	· ·	age 81 MDS dated 1/9/18, indicated	21375						
	extensive to limited person for all activit also indicated R123 influenza seasonal R125's PN dated 1/ had fallen and was A subsequent note transferred to anoth care. -A PN dated 1/16/1 the hospital and wa for influenza. -A PN dated 1/17/1 the facility with diag and urinary tract infl and assistance of co living. -A PN dated 1/18/1 attempted self trans the staff member a down to the nurse's located in the main visitor traffic flow. -A PN dated 1/18/1 continued to have a would be getting up -A PN dated 1/19/1 had expired. -R125's clinical rec	 /11/18, indicated the resident sent to the emergency room. indicated R125 was her hospital for neurological 8, indicated R125 remained in as diagnosed with and treated 8, indicated R125 returned to gnoses including influenza A, fection, required oxygen use one staff of all activities of daily 8, indicated R125 had sfers several times, therefore ssisted R125 up and took her a station which was directly in corridor of resident and 8, at 3:35 p.m. indicated R125 adventitious lung sounds and o for supper. 8, at 2:58 a.m. indicated R125 ord lacked evidence of the nfection control precautions. 							

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/27/2018	
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ige 82	21375			
	Review of R6's pro- 1/17/18, revealed fr remained in her roo was noted to have Fahrenheit, an occ voice. On 1/15/18, dining room for me- her her room as sh Further review of th January 2018, reve who had displayed -R21 displayed sym included sore throa congestion. -R10 displayed sym included vomiting, th headache. On 1/7 a non-productive cou yellow phlegm and - R9 displayed sym included a tempera with symptoms of s congestion. - R4 displayed sym included a tempera	gress notes from 1/8/18 - rom 1/8/18 - 1/14/18, R6 om. However, on 1/14/18, R6 a temperature of 99.0 degrees casional cough, and raspy R6 ambulated to and from the als. On 1/16/18, R6 remained e was not feeling well. the Infection control log for caled eight additional residents symptoms of influenza.				
	congestion. -R1 displayed symp	otoms on 1/15/18, which ture of 100.5 degrees along				
	included temperatu	otoms on 1/15/18, which re of 100.8 degrees along with chills, and sinus congestion.				

VALKER ((X4) ID PREFIX TAG 21375 (i	(EACH DEFICIENCY REGULATORY OR LS Continued From pa - R227 displayed sy included a tempera	HEALTHCARE CI TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 83 Muptoms on 1/15/18, which ture of 100.8 degrees along	B. WING DRESS, CITY, ST HWOOD AVEI , MN 56484 PREFIX TAG 21375	ATE, ZIP CODE NUE WEST PO BOX 700 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	RECTION	27/2018 (X5) COMPLET DATE
VALKER ((X4) ID PREFIX TAG 21375 (i	REHABILITATION & SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa - R227 displayed sy included a temperativith muscle aches,	HEALTHCARE CI TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 83 Muptoms on 1/15/18, which ture of 100.8 degrees along	HWOOD AVER , MN 56484	NUE WEST PO BOX 700 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE /	RECTION	(X5) COMPLET
(X4) ID PREFIX TAG 21375 (SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa - R227 displayed sy included a tempera with muscle aches,	HEALTHCARE CI WALKER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 83 mptoms on 1/15/18, which ture of 100.8 degrees along	, MN 56484	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE /	SHOULD BE	COMPLET
21375 (1 21375 (1 2 2 1 2 1 2 1 2 1 3 2 1 3 5 2 1 3 5 1 2 1 3 7 5 1 2 1 3 7 5 1 2 1 3 7 5 1 2 1 3 7 5 1 2 1 3 7 5 1 2 1 3 5 1 2 1 2 1 3 1 5 1 2 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3	(EACH DEFICIENCY REGULATORY OR LS Continued From pa - R227 displayed sy included a tempera with muscle aches,	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 83 'mptoms on 1/15/18, which ture of 100.8 degrees along	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLET
- i !	- R227 displayed sy included a tempera with muscle aches,	/mptoms on 1/15/18, which ture of 100.8 degrees along	21375			
i	included a tempera with muscle aches,	ture of 100.8 degrees along				
	- R2 displayed sym	head ache, cough, chills, and ptoms on 1/17/18, which				
	included a cough chills and sinus congestions. Additional review of the infection control logs lacked indications that the aforementioned residents had isolation precautions initiated at the time of the symptom onset.					
	improvement (QAP dated 1/16/18, iden bronchitis/respirator identified "influenza Department of Heal Assessment and Re scheduled visit had influenza A. The rep patterns/trends of ir prevention measure transmission based infections had been department, or ong analysis for the ider that hand washing of completed. In additi address any quality influenza preparatio	ty assurance performance I) committee meeting log tified infections of ry and cellulitis. Notes in house" and Minnesota Ith Infection Control esponse Program's (ICAR) to be rescheduled due to bort did not identify outbreaks, offluenza, infection control es taken such as initiation of I precautions (isolation), if the neported to the health oing monitoring systems. The ntified infections concluded competencies needed to be ion, the QAPI logs did not assurance activities for ons or prevention measures for in that began on 10/1/17.				
	(LPN)-B stated she type of isolation pre confirmed the facilit	a.m. licensed practical nurse could not recall utilizing any cautions in the facility. LPN-B ty had an outbreak of ion precautions had not been				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
VALKER	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE	NUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
21375	Continued From pa	nge 84	21375		
	utilized.				
		stated she could not recall ontrol isolation gowns in the			
	four residents who and 9 additional res symptoms. The D0	OON confirmed the facility had tested positive with influenza A sidents who displayed flu-like ON confirmed the facility had roplet precautions as directed.	x		
	and was able to loc stated the facility ha six months. NA-F j	-C opened the supply closet cate all PPE supplies. NA-C ad not utilized PPE in the past joined the conversation and ed the facility had not utilized months.			
	utilized PPE in the and masks were ut	-B stated the facility had not past year. RN-B stated gloves ilized during the influenza staff, but at no time were			
	influenza outbreak printed a sign off of it on the front door. did not have any ty notify staff, residen had a potential con stated the facility ha had not seen them	IUC stated during the in 1/2018, the former DON i the CDC website and posted The HUC stated the facility pe of signs in the facility to t or visitors, when/if a resident tagious infection. The HUC ad signs in the past but she for many years. The HUC ot recall the last time PPE was y.			
	a.m. RN-B stated i	ng visit on 3/25/18, at 8:54 nfection control education laced at the nurses station for			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00995	B. WING		03/	03/27/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
WALKER REHABILITATION & HEALTHCARE CI 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	ige 85	21375				
		gn off, however, she stated ne to review them yet.					
	had been provided	stated the only training she was related to the use of the t lift and neck brace.					
	3/27/18, at 12:00 p. the following interve	on 1/5/18, was removed on .m. when the facility completed entions were verified through nterviews and record review:	t				
	- Infection control p reviewed and upda	olicies and procedures were ted.					
	- Additional person was ordered for the	al protective equipment (PPE) a facility.					
	- All staff members PPE was located.	were educated on where the					
	- Infection control s use.	igns were ordered for future					
	control polices and	cated on the facility infection procedures, including when to n based precautions in order to of influenza.					
	Contact Precaution	s:					
	gastrostomy tube s discharge (color no documentation indi gastrostomy tube s started on an antibi	21/17, indicated R5 had a ite which was pink and had t identified). The cated a culture of the ite was obtained and R5 was otic for Methicillin Resistant SA) which is a type of staph					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		03/	03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	1		
VALKER	R REHABILITATION &	HEALTHCARE C	CHWOOD AVEN R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21375	Continued From pa	ige 86	21375				
	on 12/13/17, indica	th laboratory results collected ted R5 had Methicillin coccus at the gastrostomy					
	daily "infection note was receiving an a tube site infection v	22/17 - 12/30/17, included es." The notes indicated R5 ntibiotic for the gastrostomy vith drainage, however, the not indicate if isolation en initiated.					
	dated 12/20/17, inc with MRSA and trea	llance Data Collection Form licated R5 had been identified ated with antibiotics. The staff contact isolation precautions.					
	diagnoses that incluing a contract of the second se	to the facility on 12/15/17, with uded but were not limited to: a procedure, cerebrospinal eneralized muscle weakness,					
	12/14/17, indicated for a CSF leak follo spinal incision was staphylococcus epi R24 was given IV a	ital dismissal summary dated R24 underwent a dural repair wing a lumbar fusion. The cultured and was infected with dermis and candida albicans. Intibiotics and sent to the ceive IV antibiotics until					
	assessments and p stay in the facility (R24 had not been p precautions as iden infection control. T	edical record including all progress notes for the entire 12/15/17 - 12/22/17), revealed placed into isolation ntified by the facility's policy for he policy Isolation- Categories used Precautions dated					

	ta Department of He			CONSTRUCTION		
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00995	B. WING		03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE. ZIP CODE	•	
		209 BIRC		NUE WEST PO BOX 700		
VALKER	REHABILITATION &	WALKER	, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 87	21375			
	in contact precaution	d R24 should have been placed ons for the draining spinal h staphylococcus epidermis ins.				
	11:04 a.m. she cor in R24's record cor	ith the DON on 3/23/18, at firmed there was no indication ntact precautions were e infection control policy for ns indicated.				
	Region MRSA polic	thcare Management Minnesota cy dated 12/27/17, directed the contact precautions if resident				
	had been diagnose	2 a.m. the DON confirmed R5 ed and treated for MRSA, yet recautions had not been				
	stated she could no isolation precaution confirmed R5 had past three months	ased practical nurse (LPN)-B ot recall utilizing any type of ns in the facility. LPN-B been treated for MRSA in the and the facility had an za, yet isolation precautions ed				
	utilizing infection co past six months.	A stated she could not recall ontrol isolation gowns in the NA-A stated she had utilized the for residents who had tested or C-Diff.				
nosota Di	had isolation preca	administrator stated the facility aution supplies in the facility,				
TE FOR	epartment of Health M		⁶⁸⁹⁹ R	819311	If continuatio	n sheet 88 of

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00995	- B. WING			03/27/2018	
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE			
	REHABILITATION &		CHWOOD AVE	NUE WEST PO BOX 700			
		WALKEF	R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21375	Continued From pa	ge 88	21375				
	coordinator (HUC) located. When queried if wh practices of the fac the administrator st facility on 1/18/18, a the infection contro been reviewed for t stated the corporate annually but she did the policy review. - At 9:20 a.m. the a forward the staff we control practices an procedures, howey	d have to ask the health unit where the supplies were then the infection control ility had last been reviewed, ated she had started at the and had no records of when I policies and procedures had he facility. The administrator e level policies were reviewed d not have access to proof of dministrator stated going ere to be trained on infection ad how to implement the facility er, the staff had not received e time and it was a work in	y				
	required droplet or would have to find to protective equipment not state where the facility. LPN-B ask where the supplies LPN-B to the supplies designees office.	A-B stated that if resident isolation precautions, she the supplies for personal nt (PPE), however, she could PPE was located in the ed nursing assistant (NA)-C were located. NA-C directed y closet in the social service					
	stated the facility has six months. NA-F j	ate all PPE supplies. NA-C ad not utilized PPE in the past oined the conversation and ed the facility had not utilized months.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00995	B. WING		03/	03/27/2018	
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, SI		03/	21/2010	
	REHABILITATION &	209 BIR(NUE WEST PO BOX 700			
		WALKEF	R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	age 89	21375				
	utilized PPE in the and isolation carts had something con	-B stated the facility had not past year. RN-B stated gowns were to be utilized if a resident tagious like MRSA. RN-B MRSA in the past four months ilized.					
	Meeting dated 11/3 "The Governing bo	e Management Govern Board /17, indicated the following: ard has asked all locations to inforce infection control I departments."					
	was unaware of an training that had be	2 a.m. the DON stated she y type of infection control een completed in the past year control training was scheduled April 2018.					
	Medication adminis	stration:					
	preparing medication occasions, RN-C we bottle of medication open the bottle and bottle directly into he a soufflé cup. RN- returned the bottle	9 p.m. RN-C was observed on for R8. On three different vas observed to remove a ns from the medication cart, d dispense one pill out of the nis/her hand before adding it to C then recapped the bottle and to the cart. RN-C then carried medications into R8's room and he medications.	1				
	cart, he/she was no	C returned to the medication of observed to wash his/her dispensing medications for					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING	B. WING		27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &		CHWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 90	21375			
	individualized bubb cup. He/she then of bottle of calcium and bottle directly into he the soufflé cup. RN electronic Medication reported the calcium discontinued at whit calcium tablet from it out with his/her find	sed six tablets from le cards, directly into a soufflé opened a drawer, picked up a nd dumped one tablet from the nis/her hand before adding it to N-C then reviewed the on Administration Record and m had recently been the time he/she removed the the medication cup by picking ngers and discarding the rash. RN-C then administered R18.				
	cart and began dish RN-C was not obse prior to opening a b and placing two tab into his hand and a RN-C added three (carbidopa-levadop furmaratate) to the bubble cards. RN-	C returned to the medication hing medications for R2. erved to wash his/her hand bottle of Tylenol 325 milligrams blets directly from the bottle dding them to a soufflé cup. addition medications ba, remeron and quetipine soufflé cup from individualized C then crushed all of the dministered them to R2.				
	all medications from prior to adding them cups. RN-C stated	C confirmed he had dispensed n the bottles into his/her hand n into the resident soufflé he/she normally dished the he bottles into his hands.				
	directed the staff to	nistering Medication policy, of follow established infection during the administration of plicable.				
		0 a.m. the administrator ons were not to be dispensed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- (X3) DATE SURVEY COMPLETED - 03/27/2018	
		00995	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
WALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21375	The staff were to di	e into the staff members hand spense the medication from ap of the medication bottle, or				
	The director of nurs develop, review, an procedures to ensu- and procedures are based on current st or designee could dev ensure ongoing cor monitoring results t	HODS OF CORRECTION: sing (DON) or designee could d /or revise policies and re infection control policies e developed and implemented candards of practice. The DON educate all staff. The DON or relop monitoring systems to mpliance and report those o the quality assurance er recommendations.	1			
04.400	(21) days.	R CORRECTION: Twenty-one				5/0/4.0
21426	Prevention And Con (a) A nursing home maintain a comprel infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu	e provider must establish and bensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of bation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis on that covers all paid and contractors, students, inteers. The Department of the technical assistance	21426			5/8/18

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00995	B. WING		03/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WALKEF	R REHABILITATION &	HEALTHCARE C	HWOOD AVI MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 92	21426			
		ance with this subdivision must				
	by: Based on interview facility failed to ens received a two step accordance to the G and Prevention (CE facility failed to ens had a history of tub additional testing for failed to ensure 2 o assistants (NA-E an step TST. The facil	ent is not met as evidenced and document review, the ure 1 of 4 residents (R10) tuberculin skin test (TST) in Centers for Disease Control OC) guidelines. In addition, the ure 1 of 1 resident (R17) who erculosis had received ir tuberculosis. The facility f 5 employees/ nursing and NA-G) had received a two ity failed to complete a risk assessment for the		corrected		
	Transmission of My Health Care Setting residents must rece The baseline TB sc assessment for TB assessment for cur and testing for the p mycobacterium tub screenings, the res receive a two step laboratory screenin employee or reside	es for Preventing the vobacterium Tuberculosis in g, 2005, directed that all eive a baseline TB screening. creening should consist of risk factors and history; rent symptoms of active TB; presence of infection with erculosis. In addition to idents and employees were to tuberculin skin test (TST) or a g for the presence of TB. If an nt tested positive for any of ts, a chest x-ray and/or				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00995	B. WING		03/	03/27/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
NALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21426	Continued From pa	ige 93	21426				
		on by a medical practitioner ed to rule out active disease.					
	Residents:						
	R10's Baseline TB Home and Boarding 6/20/17, indicated step TST on 6/30/1	to the facility on 6/20/17. screening Tool for Nursing g Care Home Residents dated R10 had received a single 7. R10's medical record ion related to a second step					
	undated Baseline T Home and Boarding indicated R17 had a treated for TB in the lacked a chest x-ra	to the facility on 2/5/18. R17's B screening Tool for Nursing g Care Home Residents a history of TB and had been e past. R17's clinical record y or other documentation te if he/she was free of TB.					
	(RN)-B confirmed F step TST and R17's	0 a.m. registered nurse R10 had not received a second s medical record did not nformation related to TB	ł				
	Employees:						
	Review of the empl following information	oyee records revealed the on.					
		3/5/18. NA-E's employee de a screening for TB or a					
		3/6/18. NA-G's employee de a screening for TB or a					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
/ALKER	REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE
21426	Continued From pa	ge 94	21426		
	stated the employe should be at the nu the nurses station, unable to locate the Facility Risk Assess The undated Annua Assessment indica low risk community and RN-B would co On 11/23/18, at 8:3 the facility risk asse The administrator s clinical services (RI upon arrival to the f	al Tuberculosis (TB) Risk ted the facilty was located in a . The form indicated the DON omplete the form in April 2018. 0 a.m. the administrator stated essment was not complete. tated the regional director of DCS) had completed the form facility on 3/20/18. The med the assessment was not			
	The director of nurse develop, review, and procedures to ensure staff were properly TST was administed or designee could of ensure ongoing corr to the quality assure recommendations.	THODS OF CORRECTION: sing (DON) or designee could id /or revise policies and the facility, residents and screened for TB and that the red appropriately. The DON develop monitoring systems to mpliance and report the results ance committee for further R CORRECTION: Twenty-one			
21435		0 Subp. 1 Activity and n; General	21435		5/8/18

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00995	B. WING		03/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WALKEF	REHABILITATION &	HEALTHCARE C	HWOOD AVI , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Subpart 1. General home must provide recreation program based on each indi strengths, and need meet the physical, in well-being of each in comprehensive pla 4658.0400 and 464 provided opportunit planning and develor recreation program This MN Requirement by: Based on observati review, the facility for centered activities p individualized interv (R14) reviewed for Findings include: R14's physician nut assessment dated been admitted to th diagnoses that inclu- closed nondisplace cervical vertebra wi pressure, type II dia advanced Alzheimed disturbance. The admission Min 1/26/18, indicated F impairment, suffere fall prior to admission inappropriate behavior	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and ent is not met as evidenced ion, interview and document ailed to assess resident preferences and develop ventions for 1 of 2 residents	21435	corrected		
viinnesota D	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &			NUE WEST PO BOX 700		
		WALKER	R, MN 56484			(1.1-)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	ige 96	21435			
	ambulating in room assistance of one p required extensive dressing and toilet having books or ne around animals or	of one person when a, required extensive person for transfers, and assistance of one person for use. The MDS indicated wspapers to read, being pet visits, and participating in were somewhat important to				
	7:18 p.m., 3/21/18, and 3/22/18, from 8	on 3/20/18, from 12:48 p.m. to from 9:00 a.m. to 1:00 p.m., 3:02 a.m. to 2:30 p.m R14 ctivities and did not attend any ese times.				
	was no assessment activities of interest Care Area Assessment revealed it had not no assessment of of activity interests pri- environmental or st participation, unique resident had that co	and was reviewed and there at of leisure pursuits or a completed. R14's undated ment (CAA) for activities been completed. There was current activity interests, for to admission, taffing issues that hindered e skills or knowledge the build be passed onto others, or a reduced activity participation.				
	1/29/18, indicated t resident to activity p physical activity, ph exercise group, wa	tivities care plan dated he following: "Invite the programs that encourage hysical mobility, such as lking activities to promote R14's activity participation log not provided.				
	clinical services (R confirmed R14 had	a.m. the regional director of DCS) was interviewed and not been comprehensively ties of interest and a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		
		00995			03/27/2018
NAME OF F	PROVIDER OR SUPPLIER			ATE, ZIP CODE NUE WEST PO BOX 700	
NALKER	REHABILITATION &		R, MN 56484	NUE WEST FO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE COMP HE APPROPRIATE DA
21435	Continued From pa	age 97	21435		
		e plan with individualized ling activities of interest had d.			
	Region policy for A indicated that within admission to the fa would be assessed	hcare Management Minnesota ctivities dated 12/23/17, n 14 day of a residents cility a residents activities I for and an activity plan based oices and preferences would			
	The administrator of review, and /or revi ensure all residents activity assessmen individualized, resid The administrator of monitoring systems				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one)		
21475	MN Rule 4658.100 General Requireme	5 Subp. 1 Social Services: ents	21475		5/8/1
	home must have an department or prog related social servin nursing home must collaborate with our who is in need of a	I requirements. A nursing n organized social services gram to provide medically ces to each resident. A t make referrals to or tside resources for a resident dditional mental health, or financial services.			

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
				·	
		00995	B. WING		03/27/2018
NAME OF F	PROVIDER OR SUPPLIER				
WALKER	REHABILITATION &	HEAI THCARE C	, MN 56484	ENUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21475	Continued From pa	age 98	21475		
	by: Based on observat review, the facility f and/or arrangemen provide therapeutic	ent is not met as evidenced ion, interview and document failed to provide assistance its to obtain legal council, and conversation for 1 of 1 had urgent legal matters		corrected	
	Findings include:				
	diagnoses which in disease (kidney fai dialysis, status pos	ecord indicated R21 had acluded end stage renal lure) with dependence on renal t heart transplant, diabetes essive disorder, heart failure, mia.			
	12/20/17, indicated impairment, had m having little interess feeling tired or having trouble falling asleed displayed no inapp Review of R21's da very important for F personal belonging and have a place to keep them safe. The extensive assistant for bed mobility, training	num Data Set (MDS) dated I R21 had moderate cognitive ood symptoms which included t or pleasure in doing things, ing little energy, and had ep or staying asleep, and ropriate behavior symptoms. aily preferences revealed it was R21 to take care of his ys, use a telephone in private, o lock personal belonging to ne MDS indicated R21 required ce of more than two persons ansfers, and dressing. R21 did used a wheelchair as a mode			
	stated he was frust through a divorce a	ed on 3/20/18, at 2:11 p.m. and trated because he was going and the attorney he had			
nnesota De ATE FORM	epartment of Health		6899	RI9311 If c	ontinuation sheet 99 of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00995	B. WING		03/	03/27/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	21/2010	
		209 BIR(NUE WEST PO BOX 700			
NALKEF	R REHABILITATION &	HEALTHCARE C	R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21475	Continued From pa	ige 99	21475				
	end of February 20 attorney would no le R21 went on to say had many assets in of a business. R21 any income from th nursing home and y partners were takin stated he would cal with the aforementi cell phone but could a phone for him. R2 the staff including th designee (SSD) as was worried due no represent him in the scheduled for April						
	progress notes and 11/1/18 - 3/20/18, a had been assessed and there were no	rd was reviewed including all l assessments completed and there was no evidence R21 d for any psychosocial issues, progress notes which indicated ficulty or frustration related to onal matters.					
		essment on R21 was last 8/17, but had not identified any s at that time.	,				
	interventions for R2	ndated) was reviewed and 21's psychosocial dysfunction had not been developed.					
	3/21/18, at 1:03 p.n was aware R21 wa currently did not ha	designee was interviewed on n. during which she stated she s going through a divorce and ve a divorce attorney retained. e had not asked R21 when the					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
WALKER	REHABILITATION &	HEALTHCARE C	HWOOD AVE	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21475	Continued From pa	ige 100	21475			
	assisted R21 with t attorney (a phone, 1 number to legal aid R21 had not been a had any unmet psy 10/18/17. The SSD developed a care p periodically in order therapeutic convers psychosocial and fa On 3/23/18, at 8:43 conducted with the an attorney to repres she assisted him in pay for the attorney stated she had disc exploitation with his estranged. The SSD personal cell phone conference call with p.m The SSD state making a care plan visit with R21 at lea needed, to provide divorce. On 3/27/18, at appr interviewed again a attorney quit him ba he did not have acc even a phone to ca could not sleep at r what was going to 1 representation. R2 ⁻	cheduled, and had not he tools necessary to retain an listing of attorneys in the area, e etc). The SSD confirmed assessed to determine if he chosocial needs since confirmed she had not lan to visit with R21 r to provide ongoing sation related to R21's amily discord issues. a.m. a follow up interview was SSD who stated R21 retained esent him in his divorce and getting a prepaid VISA card to 's retainer fee. The SSD also cussed the potential of financia is wife with whom he had been D stated she got R21 a e and that they were having a n his attorney today at 4:00 red she was in the process of which indicated she would list weekly, or more often as support during this difficult roximately 9:25 a.m. R21 was and stated that when his ack in February, and he knew cess to another attorney or II one, he felt frustrated and hight due to worrying about happen if he did not get 1 also stated he had a hard uld have to force himself to				
	because when he la	was still having anxiety ast spoke to his attorney's ı that they could no longer				

Minnesc	ta Department of He	ealth			i oran	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00995	B. WING		03/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKEP	R REHABILITATION &	HEALTHCARE C	HWOOD AVE , MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	assist him. He state to follow up with hir matter. R21 stated email account and and frustration beca had an attorney ret that he needed to h to receive commun did not know how to On 3/27/18, at 9:29 had not followed up stated she was not account in order to attorney. In addition not shown R21 how stated she would as account and also lin cell phone for ease with the email addr A policy regarding p services was reque SUGGESTED MET The administrator of review, and /or revi ensure social servit addressed for each or designee could of	ed the SSD had not stopped in n on where he was at on this he did not know how to get an was still having great anxiety ause he still did not know if he ained because he was told have an email account in order ication from the attorney and	21475			
	results to the qualit further recommend TIME PERIOD FOR (21) days.	y assurance committee for				
Minnesota D	epartment of Health					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
VALKER	R REHABILITATION &	HEALTHCARE C	HWOOD AVI , MN 56484	ENUE WEST PO BOX 700	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLE
21535	Continued From pa	age 102	21535		
21535	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535		5/8/18
	unnecessary drug i A. in excessive therapy; B. for excessive D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finance This standard is inc available through th	quate indications for its use; or ince of adverse consequences dose should be reduced or lrug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State I, Guidance to Surveyors for acilities, published by the acilities, published by the lith and Human Services, corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not			
	by: Based on observat review, the facility f recommendations for 3 of 6 residents	ent is not met as evidenced ion, interview and document failed to act upon from the consultant pharmacist (R2, R23, R1) who had ndations from the pharmacist.		corrected	
	Findings include:				
		um Data Set (MDS) dated R2 with severe cognitive			

STATE FORM

RI9311

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00995	B. WING		03/	03/27/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
VALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 103	21535				
	disease, dementia indicated R2 requir all activities of daily mood or behavior p indicated R2 receiv antidepressant med R2's physician orde Seroquel (antipsycl a day, remeron (an bedtime, Prozac (a and Klonopin (moo	agnoses including Parkinson's and anxiety. The assessment ed extensive assistance with pliving and did not display problems. The assessment red daily antipsychotic and dications. ers dated 1/2/18, included hotic) 25 milligrams (mg) twice tidepressant) 7.5 mg at ntidepressant) 30 mg daily, d stabilizer) 0.125 mg one rs as needed for agitation and					
	3/21/18, at 11:30 a. receive total assista	s of personal cares on .m. R2 was observed to ance with cares from nursing R2 displayed no behaviors.					
	(EMAR) for 1/2018 received the sched Remeron as ordere Klonopin order. The documentation rela antidepressant, and medications. The E displayed any type medications. The E	dication administration record - 3/2018, indicated R2 had ule doses of Seroquel and ed. R2 had not utilized the PRN e EMAR also included daily the to potential side effects of tianxiety and antipsychotic EMAR indicated R2 had not of side effects from the EMAR did not identify R2's ed with the medications.	1				
	Medicaiton Review the pharmacist had remeron, Prozac or for a dose reduction indicated he/she ag	nsultant Pharmacist form dated 7/20/17, indicated l questioned if a the Seroquel, r Klonopin could be considered n. R2's primary physican greed with the pharmacist however, R2's family refused					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1
NALKER	REHABILITATION &			NUE WEST PO BOX 700	
(X4) ID	SUMMARY STA		R, MN 56484	PROVIDER'S PLAN OF	CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
21535	Continued From pa	age 104	21535		
	to allow a dose red	uction.			
	dated 9/19/17, indic requested non phar be attempted prior Klonopin PRN and behaviors to guide The physican indica with the recommen attempt non pharm document the findir A Consultant Pharm dated 11/21/17, ind requested the staff pharmacological im administration of th	nacist Medication Review form licated the pharmacist had to identify the non terventions utilized prior to the le medication. The pharmacist			
	the record. The prin agreement with the A Consultant Pharm	haviors were not identified in mary physican was in pharmacist findings. nacist Medication Review for cated R2 had not utilized the			
	PRN Klonopin in th if the medication co primary physican in	e past month and questioned buld be discontinued. R2's ndicated R2's family member r a dose reduction or			
	specific types of ind displayed. Nor did t non-pharmacologic the PRN Klonopin v lacked a quantitativ	ical record did not identify wha dividualized behaviors R2 the record include any cal interventions to attempt if was to be used. R2's record ve and qualitative evaluation of lationship to the medications.			
		0 p.m. registered nurse (RN)-E sultant pharmacist had made			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	IATE, ZIP CODE		
/ALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 105	21535			
	lacked documentat completed. RN-E of have a comprehen- residents behaviors altering medication R23 utilized a PRN did not receive a 14 medication. In add antidepressant medication	for R2, however, the facility ion that they had been confirmed the facility did not sive system to monitor s in relationship to their mood s. antianxiety medication and 4 day re-evaluation of the ition, R23 received an dication without adequate continued use of the				
	with severe cognitivi including dementia (inability to speak). required extensive daily living. R23 dis physical aggressive The MDS indicated	S dated 3/9/18, identified R23 ve impairments and diagnoses , history of stroke and aphasia The MDS indicated R2 assistance with all activity of splayed daily verbal and behaviors towards others. d R23 utilized antidepressant ind utilized antianxiety day review period.				
	R23 displayed daily aggressive behavior indicated R23 utiliz	dated 10/13/17, also indicated verbal and physical ors towards others. The MDS ed antidepressant medications ntianxiety medication 6 of a 7				
	Assessment (CAA) utilized antidepress medications daily.	Drug Use Care Area dated 10/19/17, indicated R23 ant and antianxiety The CAA indicated R23's elf and staff members at risk	3			
	R23's Order Summ	ary Report dated 2/23/18,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 106	21535			
	(mg) to be given da and insomnia. The 3/31/17. R23 had a (antianxiety medica administered as ne morning and evenin dose. The order w R23's care plan da a history of being p dementia. the plan medication as orde	or Trazodone 50 milligrams aily at beditme for anxiousness order had been received on a second order for Ativan ation) 0.5 mg to be reded for agitation prior to ng cares with one additional as received on 9/7/17. ted 3/27/17, indicated R23 had hysically aggressive due to directed the staff to administer r and monitor/document the fectiveness of the medication.	1			
	behaviors for the us medication. Nor w	d did not identify specific targe se of the PRN antianxiety ere non-pharmacological fied to be administered prior to ninistration.				
	administration reco received 32 dose o	ectronic medication rd (EMAR) indicated R23 had f PRN Ativan in 1/18, 48 doses es in 3/18 from 3/1/18 -	5			
	of non- pharmacolo	edical record lacked indication ogical interventions attempted he PRN medication.				
	form dated 1/20/18 pharmacist had ide antianxiety medicat a PRN antianxiety face to face evalua If the medication w	Pharmacist Medication Review , indicated the consultant ntified R23's frequent use of tion. The pharmacist indicated medication required a 14 day tion by the ordering physican. as to be continued, the record cumentation for the continued				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00995	B. WING		03/	27/2018
AME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	·	
VALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ge 107	21535			
	indicated R23 had a the occasional dose On 3/20/18, at 5:15 warned registered r assisting R23 with a R23, he had a histo at his caregivers. R1 received multipl	p.m. nursing assistant (NA)-D nurse (RN)-E that while a meal, if food was spilt on ory to attempting to strike out e psychotropic medications				
	adequate monitorin justification for their R1's quarterly MDS	ate diagnosis, without ng, and there was no r continued use. 6 dated 12/27/17, identified R1 ve impairments and diagnoses				
	including Alzheimer pressure, and type indicated R1 requir all activity of daily li symptoms of psych verbal and physical others. The MDS	"'s disease, high blood II diabetes. The MDS ed extensive assistance with ving. R1 displayed no signs of losis or delirium and had no aggressive behaviors towards indicated R1 utilized intidepressant medications				
	Assessment (CAA) utilized antipsychot medications daily w risperdone, and tra	Drug Use Care Area dated 11/3/17, indicated R1 ic and antidepressant /hich included the medications zodone. The CAA had not ny inappropriate behaviors.				
	R1's Order Summa not provided.	ry Report was requested but				
	Review of R1's mee for March 2018 indi	dication administration record				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00995	B. WING		02/	03/27/2018	
	ROVIDER OR SUPPLIER		DRESS, CITY, ST		03/	21/2010	
		209 BIRC		NUE WEST PO BOX 700			
VALKER	REHABILITATION &	HEALTHCARE C WALKER	, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	ige 108	21535				
	antipsychotic medic day and 1 mg twice behavioral disturba exact date could no or through interview Depakote Sprinkles restlessness and a antidepressant Traz be given twice a da disturbance since 4 R1's care plan date indicated R1 target wandering, being u pacing. The care pl administer medicat monitor/document to effectiveness of the changes to the phy pharmacological int activity, redirecting, environment to dec anxiety, or depress The progress notes 1/1/18-3/21/18, and incidence of inappro R1 was observed p survey on 3/20/18, 3/21/18, from 9:00 from 7:00 a.m3:00 noted that R1 did n able to verbalize, at inappropriate behav	cation risperdone 0.5 mg every e a day for dementia without nce since May of 2017 (the of be found in documentation with staff) and received is 125 MG since 1/16/2018 for gitation. R1 received the zodone 25 milligrams (mg) to by for dementia with behavioral l/28/17. ed last revised on 12/28/17, behaviors included ncooperative, and continuous an directed the staff to ion as ordered, the side effects and e medication, report behavior sician, and provide non terventions with include 1 to 1 and removing resident from rease target behaviors, ion. is for R1 were reviewed from d there were no documented opriate behavior for R1. periodically throughout the from 12:30 -8:00 p.m. on a.m. to 3:30 p.m. 3/22/18, 0 p.m. during which it was ot move on her own, was not nd had absolutely no					
	pharmacist had ide	, indicated the consultant ntified R1 had been on the morning and 1 mg twice					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		00995	B. WING		03/	03/27/2018			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE					
WALKER REHABILITATION & HEALTHCARE CI 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ^Y	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
21535	Continued From pa	age 109	21535						
	dose reduction or v clinical documentat benefit of the contin action section indic the recommendation evidence the reduc justification stateme There were no furth recommendations of risperdone, depake facility could not fin February 2018, and completed. The consultant pha 3/27/18, at 8:59 a.m pharmacy review in rispersone was for know if that diagno record by the prese the consultant phar been showing signs months. The consul- had no current beh justify the need for depakote and had any of those medic pharmacy review w recommended for of pharmacist stated to	d the physician to attempt a vrite a justification providing tion regarding the risk vs hued dose. The follow-up ated the physician accepted on, however there is no tion was attempted or clinical ent had been documented. her pharmacy regarding the use of the ote, or trazodone. However the d the recommendations from d March 2018 had not yet been armacist was interviewed on n. and stated that the n July 2017 indicated the use o end of life delirium, but did not sis had been added to R1 cribing physician. Additionally, macist did not know if R1 had s of delirium in the past three altant pharmacist confirmed R1 avior symptoms that would trazodone, risperdone, and not recommded a decrease in ations since August 2017 where only risperdone was decrease. The consultant that she had not made any ations to R1's drug regimen.	f						
		THODS OF CORRECTION:							
	develop, review, an procedures to ensu	sing (DON) or designee could nd /or revise policies and ire all recommendations armacist were reviewed and							

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			
		00995				
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
/ALKER	REHABILITATION &	HEAI THCARE C	HWOOD AVE , MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ge 110	21535			
	acted upon. The DC monitoring systems compliance.	DN or designee could develop to ensure ongoing				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.1315 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			5/8/18
	monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medic medical director is not the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee re the attending physic	g. A nursing home must ent's drug regimen for isage, based on the nursing I procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the al director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not ne matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director, macist shall refer the matter				
	by: Based on observati	ent is not met as evidenced on, interview, and document ailed to ensure residents who		corrected		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
VALKER	REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21540	Continued From pa	age 111	21540				
	 medications had rational for utilization of the medication longer than 14 days. This practice affected 3 of 3 residents (R23, R2, R3) with orders for antianxiety medications. In addition, the facility failed to adequately monitor psychoactive medications regarding efficacy and on-going need for 5 of 6 residents (R23, R2, R6, R1, R3) reviewed for psychotropic medications. Finding include: R23 utilized a PRN antianxiety medication and the record did not contain a rational or duration of use for utilization of the medications greater than 14 days. In addition, R23 received antidepressant medication without adequate monitoring for the continued use of the medication. 						
	3/9/18, identified R impairments and d history of stroke an The MDS indicated assistance with all displayed daily veri behaviors towards R23 utilized antide	nimum data set (MDS) dated 23 with severe cognitive iagnoses including dementia, ad aphasia (inability to speak). I R23 required extensive activities of daily living. R23 bal and physical aggressive others. The MDS indicated pressant medications daily and medication 6 of a 7 day review					
	R23 displayed daily aggressive behavior indicated R23 utiliz	dated 10/13/17, also indicated y verbal and physical prs towards others. The MDS red antidepressant medications ntianxiety medication 6 of a 7 <i>v</i> iew period					
		c Drug Use Care Area) dated 10/19/17, indicated R23	3				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21540	Continued From p	age 112	21540			
	utilized antidepressant and antianxiety medications daily. The CAA indicated R23's behaviors put himself and staff members at risk for injury.					
	included an order of 50 milligrams (mg) for anxiousness are been received on 3 order for Ativan (are administered as no morning and even	nary Report dated 2/23/18, for Trazodone (antidepressant)) to be given daily at beditme nd insomnia. The order had 3/31/17. R23 had a second ntianxiety) 0.5 mg to be seded for agitation prior to ing cares with one additional roughout the day. The order /7/17.				
	a history of being p dementia. The pla medication as orde	ated 3/27/17, indicated R23 had obysically aggressive due to n directed staff to administer ered and monitor/document the fectiveness of the medication.				
	behaviors for the u medication. Nor w	rd did not identify specific targe use of the PRN antianxiety vere non-pharmacological ified to be attempted prior to ministration.	,t			
	administration received 32 doses	lectronic medication ord (EMAR) indicated R23 had of PRN Ativan in 1/18, 48 23 doses in 3/18 from 3/1/18 -				
	of non- pharmacol	nedical record lacked indication ogical interventions attempted the PRN medication.				
		Pharmacist Medication Review 3, indicated the consultant				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
NALKER	REHABILITATION &	HEALTHCARE C	HWOOD AVE	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21540	Continued From pa	ge 113	21540				
21540	antianxiety medicat a PRN antianxiety r required clinical doo for the continued ne R23's primary phys indicated R23 had the occasional dose did not indicate wha interventions were administration of th On 3/20/18, at 5:15 warned registered r assisting R23 with a	ician replied on 1/26/18, and significant anxiety and requirec es of Ativan. The physician at type of non pharmacological to be attempted prior to the					
	clinical services (RI record and confirm R23's target behavi the as needed antia record did not conta PRN ativan for a tir days. Non pharma been identified and had not been evalu RDCS stated the fa	p.m. the regional director of DCS) reviewed R23's clinical ed the facility had not identified iors for the continued use of anxiety medication. R23's ain a rational for the use of the ne period of greater than 14 cological interventions had not the antidepressant medication ated on a quarterly basis. The neility did not have a system to n relationship to their ions.					
	receive assistance	a.m. R23 was observed to with personal cares by NA-B empted to hit and kick at the					
mesota De		3 a.m. RN-B stated R23's yelling, kicking and pinching					

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NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
VALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21540	Continued From pa	age 114	21540				
	a drink or reapproa required a PRN Ativ not have a system pharmacological in administration of th R2 received antipsy adequate monitorin medication. In add medication and the a rational or duratio medication utilized R2's annual MDS of with severe cognitivi including Parkinsor anxiety. The assess extensive assistant living and did not di problems. The assess received daily antip medications.	terventions prior to the e medication. ychotic medications without ng for the continued use of the ition, R2 had PRN antianxiety c clinical record did not contain on of use for the antianxiety greater than 14 days. lated 11/2/17, identified R2 ve impairments and diagnoses n's disease, dementia and asment indicated R2 required ce with all activities of daily isplay mood or behavior sessment indicated R2 sychotic and antidepressant					
	Assessment (CAA) received antipsych	Medicaiton Care Area dated 11/3/17, indicated R2 otic and antidepressant e staff was to monitor for side cations.					
	order for Seroquel (mg) twice a day, re mg at bedtime, Pro daily, and Klonopir	ers dated 1/2/18, included an (antipsychotic) 25 milligrams emeron (antidepressant) 7.5 izac (antidepressant) 30 mg n (antianxiety) 0.125 mg one rs as needed for agitation and					
		ed 12/28/17, indicated R2 c medication. The plan					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
	REHABILITATION &		CHWOOD AVE	NUE WEST PO BOX 700	
		WALKER	R, MN 56484		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
21540	Continued From pa	ige 115	21540		
	directed the staff to monitor for target behaviors and document, monitor R2's behaviors, provide non-pharmaceutical interventions that included one on one interventions, redirecting and changing position. The plan also directed the staff to evaluate for the effectiveness of the medications.				
	3/21/18, at 11:30 a. receive total assista	s of personal cares on m. R2 was observed to ance with cares from nursing At no time was R2 observed to behaviors.			
	(EMAR) for 1/18- 3 the schedule doses ordered. R2 had mo order. The EMAR a documentation rela antidepressant, and medications. The B displayed any type medications. The B	dication administration record /18, indicated R2 had received s of Seroquel and Remeron as ot utilized the PRN Klonopin also included daily ted to potential side effects of ianxiety and antipsychotic EMAR indicated R2 had not of side effects from the EMAR did not identify R2's a she was receiving the			
	Medication Review the pharmacist had remeron, Prozac or for a dose reduction indicated he/she ag	nsultant Pharmacist form dated 7/20/17, indicated quested if the Seroquel, Klonopin could be considered n. R2's primary physican greed with the pharmacist however, R2's family refused uction.			
	form dated 9/19/17 requested non pha	rmacist Medication Review , indicated the pharmacist had rmacological interventions be administration of the PRN			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/	27/2018
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		03/	27/2018
		209 BIR(NUE WEST PO BOX 700		
WALKER	REHABILITATION 8		R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21540	Continued From pa	age 116	21540			
	Klonopin and to identify the target behaviors to guide the use of the medication. The physican indicated he/she was in agreement with the recommendation and directed the staff to attempt non pharmacological interventions and document the findings.					
	form dated 11/21/1 had requested the pharmacological in administration of th indicated target be the record. The pr	armacist Medication Review 7, indicated the pharmacist staff to identify the non iterventions prior to the me medication. The pharmacist haviors were not identified in imary physican was in e pharmacist findings.				
	form dated 2/23/18 the PRN Klonopin questioned if the m discontinued. R2's R2's family member	rmacist Medication Review 8, indicated R2 had not utilized in the past month and nedication could be s primary physican indicated er refused to consider a dose ontinuation of the medication.				
	which the primary	ned an order dated 1/15/18, in physican requested to have R2 ntal health practitioner.				
	indicated during the member was prese hallucinations in the distress during pas	ealth evaluation dated 3/15/18, e evaluation R2's family ent and reported R2 displayed e past and had suffered severe st attempts at medication fore, the medications were not mily request.				
	specific types of be the record include	nical record did not identify wha ehaviors R2 displayed. Nor did any type of cal interventions to attempt if	t			

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		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
NALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21540	Continued From pa	ige 117	21540			
	the PRN Klonopin was to be used. R2's record lacked a quantitative and qualitative evaluation of her behaviors in relationship to the medications. On 3/22/18, at 2:50 p.m. registered nurse (RN)-E stated the facility staff was to identify R2's target behaviors, monitor the behaviors and complete a monthly evaluation of the behaviors in		=			
	relationship to the r facility did not have the behaviors and a was reviewing the e R2's PRN Klonopin however, R2's pow the medication to b clinical record did n which the risks and	of the behaviors in medications. RN-E stated the a system in place to monitor at this time no staff member efficacy of the medications. had not been utilized, er of attorney refused to allow e reduced. RN-E stated R2's not include documentation in benefits of the medications d with the family member.				
		0 a.m. registered nurse lid not display any type of				
	R6 received antian: adequate behavior	xiety medications, without monitoring.				
	with moderate cogr diagnoses including atrial fibrillation and MDS also identified having little energy assessment period	6 dated 1/17/18, identified R6 hitive impairments and g depressive disorder, chronic l mitral valve disease. The l R6 as feeling down and 2-6 days during the . R6 did not display behaviors assistance of one staff for all ing.				
	as having little to no	S dated 6/29/17, identified R6 o interest in doing things, epressed and feeling bad				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED			
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE					
WALKER REHABILITATION & HEALTHCARE CI 209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484									
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21540	Continued From pa	ige 118	21540						
		display any type of adverse ne of the assessment.							
	indicated R6 utilize anxiety and Zoloft (AA directed the staff to monitor							
	included an order for The Buspar was sta depressive disorde	ary Report dated 3/5/18, or Buspar 10 mg every day. ared on 10/17/17, for "major r." R6 also had an order dated 20 mg daily for the treatment e disorder.							
	administer medicat for side effects. R6	ed 12/1/17, directed the staff to ions as ordered and monitor 's care plan did not identify r the continued use of the tions.							
	3/27/18, R6 was no of behaviors. For e p.m. R6 was obser eating the noon me residents, converse	conducted from 3/19/18, - ot observed to display any type example, on 3/21/18, at 12:25 ved in the main dining room eal. R6 sat with two other ed with the other residents and ugh with the meal, wheeled ining room.							
	and March 2018, in generic symptoms hopelessness, anxi anorexia, verbalizin repetitive anxiety an indicated R6 never	AR's for January, February idicated staff monitored R6 for of depression including iety, sadness, insomnia, ig negative statement, nd tearfulness. The EMAR's displayed any of the ncerns. The EMAR did not							

	IT OF DEFICIENCIES OF CORRECTION	CALL CALL CALL CALL CALL CALL CALL CALL		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00995	B. WING	B. WING		27/2018
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WALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
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21540	Continued From pa	age 119	21540			
	identify specific ind R6.	identify specific individualized target behaviors for R6.				
	Report dated 3/15/ antidepressant med 1/18, from Zoloft to the psychiatric nurs reduce R6's antian to monitor R6's ant	alth Psychiatric Progress 18, indicated R6's dications had been changed in Celexa. Due to the change, se practitioner had opted not to xiety medication and continue idepressant medications. R6 behaviors at the time of the				
	3/21/18, revealed n evaluation of R6's b antidepressant med 1/18/18. The notes analysis of R6's be	gress Notes dated 1/8/18, - to documentation of an behaviors after the dications were changed on also lacked a comprehensive haviors/symptoms being antianxiety medication.				
	staff was to identify the behaviors and o of the behaviors in medications. RN-E a system in place to	E stated the facility did not have o monitor the behaviors and at ember was reviewing the	9			
	without an appropri	le psychotropic medications iate diagnosis, adequate fication for continued use.				
	with severe cognitiv including Alzheimer pressure, and type indicated R1 requir	6 dated 12/27/17, identified R1 ve impairments and diagnoses r's disease, high blood II diabetes. The MDS ed extensive assistance with v living. R1 displayed no signs				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NALKEF	R REHABILITATION &		CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 120	21540			
	or symptoms of psychosis or delirium and had no verbal or physical aggressive behaviors towards others. The MDS indicated R1 utilized antipsychotic and antidepressant medications daily.					
	Assessment (CAA) utilized antipsychot medications daily v risperdone, and tra	Drug Use Care Area) dated 11/3/17, indicated R1 ic and antidepressant vhich included the medications izodone. The CAA had not ny inappropriate behaviors.				
	R1's Order Summa not provided.	ary Report was requested but				
	for March 2018, ind antipsychotic media day and 1 mg twice behavioral disturba was not found in th with staff) and rece (mood stabilizer) 12 restlessness and a Trazodone (antidep	dication administration record dicated R1 received the cation risperdone 0.5 mg every e a day for dementia without ince since 5/17 (exact date re record or through interview eived Depakote Sprinkles 25 mg since 1/16/18, for gitation. R1 received pressant) 25 mg to be given nentia with behavioral 4/28/17.	/			
	indicated R1 target wandering, being u pacing. The care p medication as orde side effects and eff report behavior cha provide non pharm include 1:1 activity,	ed last revised 12/28/17, t behaviors included incooperative, and continuous lan directed staff to administer ered, monitor/document the fectiveness of the medication, anges to the physician, and acological interventions with redirecting, and removing onment to decrease target				

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/27/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		03/	2112010
		209 BIR		NUE WEST PO BOX 700		
NALKER	R REHABILITATION &		R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 121	21540			
	form dated 8/25/17 pharmacist had ide Risperdone 0.25 in daily and requested dose reduction or v clinical documentation benefit of the contin action section indic the recommendation indication statement There were no furth recommendations of risperdone, depakt facility could not fin 2/18, and 3/18, had The progress notes 1/1/18-3/21/18, and incidences of inapp R1 was observed p survey on 3/20/18, 3/21/18, from 9:00 from 7:00 a.m3:00 noted R1 did not m	harmacist Medication Review , indicated the consultant entified R1 had been on the morning and 1 mg twice d the physician to attempt a write a justification providing tion regarding the risk vs hued dose. The follow-up tated the physician accepted on, however there was no attempted or clinical ent had been documented. her pharmacy regarding the use of the ote, or trazodone. However the d the recommendations from d not yet been completed. s for R1 were reviewed from d there were no documented propriate behavior for R1. beriodically throughout the from 12:30 -8:00 p.m. on a.m. to 3:30 p.m. 3/22/18, 0 p.m. during which it was love on her own, was not able ad no inappropriate behaviors.				
	clinical services (R medication record	a.m. the regional director of DCS) reviewed R1's and progress notes and				
	for the use of risper progress notes had inappropriate beha	vior symptoms R1 had				
	and pacing is not a	18-3/22/18, and wandering ppropriate indications for the trazodone, and depakote.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00995	B. WING		03/27/2018
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
VALKER	REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700	
(X4) ID PREFIX TAG			MARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF O EFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT		
21540	Continued From pa	ge 122	21540		
	R3's as needed (PRN) Ativan lacked duration and documented physician rational for exceeding beyond a 14 day duration. R3's face sheet dated 3/23/18, included diagnoses of asthma and chronic respiratory failure. A communication note from the hospice service to a physician dated 2/26/18, requested R3's scheduled Ativan (antianxiety) 0.5 mg every four hours be changed to 0.5 mg PRN every four hours because the scheduled dose caused increased drowsiness. The physician's response on the communication identified agreement and orders to change Ativan to 0.5 mg every for hours as needed for anxiety. The order lacked a duration for use. R3's record lacked evidence of a physician's evaluation to extend the duration for use of the Ativan beyond 14 days.				
	indicated between 3	ministration record (MAR) 3/1/18, and 3/23/18, Ativan 0.5 ed on 40 occasions.			
	(RN)-E indicated th documented a ratio Ativan. RN-E stated physician was resp	2 a.m. registered nurse e physician should have onal and a duration for the PRN d she thought the hospice onsible for ensuring entation for PRN psychotropic			
	indicated PRN psyc	7 a.m. the administrator chotropic medication beyond physician justification and			
	Region policy and p	e Management Minnesota procedure dated 12/23/17, / will make every effort_to			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00995	B. WING		03/	03/27/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
VALKER	REHABILITATION &		CHWOOD AVEN R, MN 56484	NUE WEST PO BOX 700			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE	
21540	Continued From pa	age 123	21540				
	to the use of psych to include regular r appropriate dosage benefits. Additional of determining the symptoms so the a environment, medi	and federal regulations related opharmacological medications eview for continued need, e, side effect, risks and/or ly, the facility supports the goa underlying cause of behavioral ppropriate treatment of cal, and/or behavioral ell as psychopharmacological e utilized.	1				
	The director of nurs develop, review, ar procedures to ensu- regimes were free medications. The D	THODS OF CORRECTION: sing (DON) or designee could nd /or revise policies and ure all residents medications from unnecessary DON or designee could develop s to ensure ongoing)				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21810	Residents of HC Fa	-	21810			5/8/18	
	residents shall hav medical and person needs. Appropriate care designed to en highest level of phy This right is limited	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means nable residents to achieve their vsical and mental functioning. where the service is not ablic or private resources.					
	This MN Requirem	ent is not met as evidenced					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/27/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
WALKER	R REHABILITATION &		CHWOOD AV R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21810	Continued From pa	age 124	21810			
	review, the facility f accommodation of within reach for 1 o repeated falls.	ion, interview and document failed to ensure reasonable need related to call lights of 2 residents (R14) with		corrected		
	Findings include: R14's physician nursing home admission assessment dated 1/23/18, indicated R14 had been admitted to the facility on 1/19/18, and had diagnoses that included, but were not limited to: closed nondisplaced fracture of the seventh cervical vertebra with routine healing, high blood pressure, type II diabetes, late onset moderately advanced Alzheimer's disease with behavioral disturbance.					
	1/26/18, indicated I impairment, suffer fall prior to admissi inappropriate beha limited assistance of ambulating in room assistance of one p extensive assistance	imum Data Set (MDS) dated R14 had moderate cognitive ed a fracture as a result of a on, not displayed any vior symptoms, required of one person when n, required extensive person for transfers, required ce of one person for dressing was frequently incontinent of				
	laying in bed in his had a cervical colla to a thoracic lumba stabilizing brace the and abdomen. R14 (approximately 12 i there was fall mat p	on 3/20/18, at 12:48 p.m. bedroom. It was noted R14 ar around the neck connected ar sacral orthosis (TLSO) at wrapped around the back I's bed was low to the floor inches from the floor) and blaced next to the bed. R14 ded the call light to summon				

	ta Department of He T OF DEFICIENCIES				(X3) DATE SURVEY	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
		00995	B. WING		03/2	27/2018
JAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE ZIP CODE	1	
		209 BIR(NUE WEST PO BOX 700		
WALKER	REHABILITATION &		R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	age 125	21810			
	assistance. R14 was again observed on 3/20/18, from 5:54 p.m. to 6:48 p.m. while seated up in the wheelchair in his bedroom. At no time did any facility staff stop into R14's room to check on R14 for safety. R14 did not have access to the call light to summon assistance.					
	during which it was evening care and a to wear the TLSO, mat next to the bed	on 3/20/18, at 7:18 p.m. s noted R14 was provided assisted to bed. R14 continued was in a low bed with a fall d. R14 had not been provided a n assistance at the end of				
	the dining room an wheelchair and pla where he actively v) a.m. R14 was removed from d assisted to his bedroom via a ced in front of the television vatched a television program. ded a call light to summon	a			
	the following interv sure the resident's encourage the resi	are plan for falls dated 1/24/18, entions were developed: Be call light is within reach and dent to use it for assistance as ent needs prompt response to sistance.				
	was interviewed re during which she c been provided the	or of clinical services (RDCS) garding R14's fall incidents onfirmed R14 should have call light to summon nimize fall incidents.				
	Region policy for A (undated) indicated	thcare Management Minnesota nswering the Call light d in step 5. When a resident is				
nesota De ATE FORM	epartment of Health /		6899 R	819311	If continuation	sheet 126 of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00995			03/	03/27/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
VALKER	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	ENUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ^Y	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	ge 126	21810			
	bed or confined to a within easy reach o	a chair make sure call light is f the resident.				
	The director of nurs develop, review, an procedures to ensu light within reach. T educate all appropr designee could dev ensure ongoing cor	THODS OF CORRECTION: sing (DON) or designee could d /or revise policies and re all residents have a call he DON or designee could iate staff. The DON or elop monitoring systems to npliance and report those y assurance committee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21885	MN St. Statute 144 Residents Of HC F	.651 Subd. 21 Patients & ac.Bill of Rights	21885			5/8/18
	and residents may privately with perso and, except as prov Commitment Act, le choose. Personal r interference and re- medically or progra and documented by	unication privacy. Patients associate and communicate ns of their choice and enter vided by the Minnesota eave the facility as they mail shall be sent without ceived unopened unless mmatically contraindicated y the physician in the medical ns indicated of this subdivision ssment.)	n			
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview and document ailed to ensure resident mail aturdays and reasonable		corrected		

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WALKER	REHABILITATION &			NUE WEST PO BOX 700		
		WALKEF	R, MN 56484			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21885	Continued From pa	age 127	21885			
	access to the Internet was provided. This had the potential to affect all 23 residents residing in the facility.					
	Findings include:					
	3/20/18, at 2:29 p.r	council meeting held on n. R17 and R13 both stated nail was not being delivered or				
	confirmed the resid) a.m. nursing assistant (NA)-E lents' mail was not delivered had not been for about the pas				
	and director of nurs unaware the reside being delivered on stated she would a	88 a.m. both the administrator sing (DON) stated they were ents' personal mail was not Saturdays. The administrator ssign a staff member to begin on Saturdays, as required.				
	NA-B and NA-F sta computer for the re	roximately 9:00 a.m. both ated they thought there was a esidents to use in the resident t least there used to be."				
	there used to be a for the residents to the room, confirme if the residents war	administrator and DON stated computer in the lounge room use and upon observation of d it was not there. Both stated nted a computer to use, they ter in the activity room.				
	policy and procedu the residents would in contact with fam mail services. The	e Management Resident Mail re dated 12/23/17, indicated d have the opportunity to stay ily/friends/community through Living Center would provide				
nesota D ATE FORI	epartment of Health M		6899 E	RI9311	If continuation	sheet 128 of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
VALKER	REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21885	Continued From pa	age 128	21885			
	within 24 hours of r request to send ma delivery. Reasonab would also be prov SUGGESTED MET The administrator of review, and /or revi ensure mail was de delivered by the Ur electronic means of for resident use, if of could educate all a administrator or de monitoring systems	THODS OF CORRECTION: or designee could develop, se policies and procedures to elivered every day mail is nited States Postal Service and f communication was available desired. The administrator ppropriate staff. The esignee could develop s to ensure ongoing port those results to the quality	•			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			5/8/18
	reporter who has revulnerable adult is or who has knowled has sustained a ph reasonably explain information to the co individual is a vulne the individual is adur reporter is not requi	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected a individual that occurred prior ss:				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00995	B. WING		03/	27/2018
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VALKEF	R REHABILITATION &	HEALTHCARE C	CHWOOD AVE R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	age 129	21980			
	 (1) the individual way another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in thi known or suspecter knows or has reased been made to the c (d) Nothing in thi reporter from also reason to believe the 626.5572, subdivision. If the reported error w the criteria under section when mee 626.5572, subdivision (5). The lead ager information when met conter subdivision when met conter section when met contex section	as admitted to the facility from the reporter has reason to ble adult was maltreated in the knows or has reason to believe is a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the section may voluntarily report as section requires a report of d maltreatment, if the reporter on to know that a report has common entry point. Is section shall preclude a reporting to a law enforcement reporter who knows or has nat an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ine or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining its the criteria under section ion 17, paragraph (c), clause make an error under section of agency information explaining its the criteria under section ion 17, paragraph (c), clause not shall consider this naking an initial disposition of				
	by:	ent is not met as evidenced , and document review, the		corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00995	B. WING		03/	27/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•	
WALKEF	R REHABILITATION &		CHWOOD AVEI R, MN 56484	NUE WEST PO BOX 700		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 130	21980			
	neglect of care and injuries of unknown source were reported timely to the administrator and/or State agency for 1 of 1 resident (R13) who was intentionally hit by another resident, and for 1 of 1 resident (R226) who had eloped from the facility, twice. In addition, the facility failed to report injuries of unknown source to the State agency for 1 of 1 resident (R5) who was found to have a left forearm bruise of unknown source.					
	Findings include:					
	a.m. that R21 used currently lived a co- he could not get alo would threaten to " being just two days months ago, when with staff present, F punched him in the being injured. R13 witnessed the incid down." R13 denied "all he is, is one big	nterview on 3/19/18, at 9:24 to be his roommate and uple doors from him, however, ong with R21. R13 stated R21 beat him up" most recently ago. R13 stated about two he was by the nursing station R21 had "rolled up and left shoulder." R13 denied stated the staff who had ent told R21 he had to "settle being afraid of R21 and stated mouth" and that he tried to 1 as much as he could.				
	stated R21 and R1 did not get along an so they got separat currently, when R13 room, R21 would c approximately four staff member who member it was, hav go up to R13 and p stated as staff were	p.m. nursing assistant (NA)-B 3 used to be roommates who nd would swear at each other re rooms. NA-B stated 3 would wheel past R21's all R13 names. NA-B stated months ago, she and another she could not recall which staff d witnessed R21 intentionally punch him in the arm. NA-B e moving R13 away from R21, 1 the "F-word." NA-B stated				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00995		B. WING		03/27/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE	
ALKER	REHABILITATION &		CHWOOD AVE	NUE WEST PO BOX 700	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE DATE
21980	Continued From pa	age 131	21980		
	also stated she had nurse but was not had reported to. The aforementioned res- was reported to the agency, within two R226 eloped from facility's computeria- list. The note indica- within the facility so search was conduc- locating R226 and called, they informed resident was at the police returned the unharmed. The fac- facility Minnesota II Management List w 7:30 a.m. and revise R226 had eloped fit temporary wander 15 minute checks w lacked evidence the On 3/20/18, at 6:30 was not happy abo eloped from the fac- stated the incident was not the only tir attempted to leave another incident wi police department to go pick up R226	een the two residents. NA-B d reported the altercation to a 100% sure which nurse she he facility lacked evidence the sident to resident altercation e administrator or the State hours as required. the facility according to the zed Risk Management Incident ated R226 could not be located of a building and grounds cted which was unsuccessful in 911 was called. When 911 was ed the facility their missing e local police department. The resident to the facility, cility provided a copy of their ncident Report from the Risk which was dated 12/3/17, at sed on 12/5/17, which indicated rom the facility and a guard was placed, and every were initiated. However, it e Stage agency was notified. 0 p.m. cook (C)-A stated R226 but being at the facility and had cility a couple of times. C-A with the police department ne R226 had gotten away or the facility. C-A recalled hich occurred "way" before the incident, where he was going after he had left the facility in at a gas station which was			
	"somebody" had ca the staff that one o	lice department. C-A stated alled the facility and informed f their residents was there, nebody" had given R226 a ride			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	00995		B. WING		03/	03/27/2018	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			21/2010	
		209 BIR(NUE WEST PO BOX 700			
VALKER	REHABILITATION &	HEALTHCARE CI WALKER	R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From page 132		21980				
	back to the facility is C-A stated R226 us have had to get dow down the middle of area of the road that following the snow being appropriately temperature. R226 evidence of this pri- documentation indi- reported to the adm R5's Progress Note indicated R5 had a bruise which was y pinkness surroundi- documentation did was located on R5. Set (MDS) dated 1/ cognitive impairme activities of daily liv A Resident Bruise/ 3/13/18, indicated F bruise on the right caused by an arm F and director of nurs However, the State 24 hours as require source. On 3/20/18 at 1:41	before he could go get him. Sed a wheelchair and would wntown by wheeling himself the street as that was the only at had been plowed open fall. C-A remembered R226 dressed for the cold winter 's medical record lacked or elopement as well as cating the incident had been hinistrator or State agency. e dated 3/13/18, at 11:20 p.m. 6.0 centimeter (cm) by 3.0 cm yellow/green in color with some					
	procedures, the ad nursing (DON) stat it within the facility. -At 1:49 p.m. the ac confirmed R13's ar	ministrator and director of ed they were unable to locate dministrator and the DON nd R21's dislike for each other.					
	The administrator,	the DON and the regional					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	00995		B. WING		03/	03/27/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		1 00/	21/2010	
		209 BIR(NUE WEST PO BOX 700			
ALKER	REHABILITATION &		R, MN 56484				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From page 133		21980				
	director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred and confirmed it should have been reported to the administrator as well as the State agency, as required.						
	RDCS, and the DO from the facility and When asked about program related to the whole system r administrator state started at the facilit failure in the system	b p.m. the administrator, N confirmed R226 had eloped the incident was not reported the facility's abuse prevention reporting, the RDCS stated needed to be "revamped." The d when her and the DON y, they became aware of the n and had begun educating use prevention program dures.	-				
	had only been with company for three time at the facility. the Superior Health executive who over executive stated th of the facility on 2/1 former employee w facility through the which ended June started working at t for overseeing the November 2017. For departure, there wa assigned to this "pr supervisor was not available for consu	a.m. the RDCS stated she the facility's management weeks and this was her first At this time, the RDCS called neare Management (SHM) rseen this facility. The e company took over operation 1/17, whereas there was a who continued to work at the ownership transition phase 2017, at which time a RDCS the facility and was responsible clinical nursing operation until ollowing this employee's as no specific regional director roperty" therefore a clinical present on site, rather was ltation via the phone. The acknowledged the lack of	9				

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00995	B. WING		03/27/201	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
REHABILITATION &	HEALTHCARE C		NUE WEST PO BOX 700		
		ID			(X5)
		PREFIX TAG			COMPLET DATE
Continued From page 134		21980			
program policy and staff education.	procedures in and provide				
•					
abuse protocol bec					
Healthcare Manage Investigation policy facility would notify licensing agencies of circumstances of th compliance with Fe and Elder Justice A Facility Managemen indicated it was the employees to prom suspected incident including injuries of misappropriation of management. The a immediately notified incidents of abuse.	ement Abuse Reporting and revised 1/30/17, indicated the the State agency and other depending on the le allegation or actual event in deral and State regulations ct. The Reporting Abuse to nt policy and procedure responsibility of their ptly report any incident or of neglect or resident abuse, unknown source, and theft or resident property to facility administrator or DON must be d of suspected abuse or actual The undated Resident to				
Resident Altercation	ns policy and implementation				
represent resident t	o resident abuse would be				
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On 3/26/18, at 3:26 p.m. licensed practical nurse (LPN)-A stated she was shown the newly created facility abuse prevention program binder last "Tuesday" (six days prior) and verified the binder was kept at the nurses station and contained the facility's policy and procedures related to abuse prohibition in which staff were to refer to when needed. However, LPN-A stated she did not know if any changes had been made to the facility's abuse protocol because she had not reviewed the information yet. On 3/22/18, the RDCS provided a Superior Healthcare Management Abuse Reporting and Investigation policy revised 1/30/17, indicated the facility would notify the State agency and other licensing agencies depending on the circumstances of the allegation or actual event in compliance with Federal and State regulations and Elder Justice Act. The Reporting Abuse to Facility Management policy and procedure indicated it was the responsibility of their employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The administrator or DON must be immediately notified of suspected abuse or actual incidents of abuse. The undated Resident to Resident Altercations policy and implementation form indicated all altercations including those that represent resident to resident abuse would be reported to the nursing supervisor, DON and to the administrator. The undated Elopements policy interpretation and implementation form indicated staff would report all cases of missing residents	WALKER, MN 56484 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 134 21980 program policy and procedures in and provide staff education. 21980 On 3/26/18, at 3:26 p.m. licensed practical nurse (LPN)-A stated she was shown the newly created facility abuse prevention program binder last "Tuesday" (six days prior) and verified the binder was kept at the nurses station and contained the facility's policy and procedures related to abuse prohibition in which staff were to refer to when needed. However, LPN-A stated she did not know if any changes had been made to the facility's abuse protocol because she had not reviewed the information yet. 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Minnesc	Minnesota Department of Health							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		00995	B. WING		03/2	7/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
WALKER	R REHABILITATION &		HWOOD AVI , MN 56484	ENUE WEST PO BOX 700				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
21980	The administrator of review, and /or revi ensure all allegation reported to the Stat directed. The admin educate all appropri designee could dev ensure ongoing con results to the qualit further recommend	THODS OF CORRECTION: or designee could develop, se policies and procedures to ns of abuse and neglect were te Agency and/or adminstrator nistrator or designee could riate staff. The administrator or velop monitoring systems to mpliance and report those y assurance committee for	21980					
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