Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2023

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

RE: CCN: 245618
Cycle Start Date: July 20, 2023

Dear Administrator:

On July 20, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 20, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 20, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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August 15, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: TUN011

Dear Administrator:

The above facility was surveyed on July 17, 2023 through July 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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E 000	Initial Comments On 7/17/23 to 7/20/23, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. Walker Methodist Westwood Ridge II was found in compliance with the requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/17/23 to 7/20/23, a standard recertification survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDS). In addition, multiple complaint investigations were completed. Walker Methodist Westwood Ridge II was found to be not in compliance with 42 CFR 483, Subpart B, the requirements for Long Term Care Facilities. The following complaints were reviewed: H56183540C (MN00088569) H56183541C (MN00087708) H56183622C (MN00091712) H56183623C (MN00089508) H56183624C (MN00084960) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

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

Electronically Signed | 08/25/2023

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 553		9/8/23

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F 553	Continued From page 2 (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide an opportunity for participation in care plan development for 1 of 1 resident (R177) reviewed for participation in care planning. Findings included: R177's Admission Record dated 7/21/23, indicated R177 was admitted to the facility on 7/4/23. R177's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/23, indicated R177 was cognitively intact, had no behaviors or mood concerns, and indicated it was very important to have family involved in discussions about care. The MDS indicated, R177 needed assistance of one staff member with transfer, ambulation, bathing, and dressing. Diagnoses included progressive neurological condition, reaction due to neurostimulator implant of the brain, hypertension, diabetes mellitus, non-Alzheimer's dementia and Parkinson's (a disorder of the central nervous system that affects movement, often including tremors) disease. R177's Order Summary Report included a nursing order dated 7/15/23, "Tabs alarm placed for safety; ensure plugged in and functioning q [every] shift." R177's Care Plan created 7/4/23, indicated R177 was at risk for falls related to Parkinson's disease and directed staff to anticipate R177's needs, to	F 553	This plan of correction constitutes our 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 Corrective action(s) accomplished for those patients found to have been affected by the deficient practice: On 7/18/23, patient, family and provider notified about use of tab alarm device for safety monitoring and to prioritize patient care needs. On 7/21/23, nurse coordinator discussed decision to keep tab alarm device in place with R177 and family. Per R177 and family, tab alarm device appropriate until discharge. Care plan reviewed and updated. R177 discharged from facility on 7/24/23. Corrective action taken to identify other patients having the potential to be affected by the same deficient practice: Facility audit performed. Proper notification of use and care planning documentation in place for all other patients with tab alarm device. Systematic change(s) to ensure deficient	

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F 553	Continued From page 3 be sure the call light was within reach and to encourage R177 to use it for assistance as needed. R177's Physical Devices Consent was signed by R117's family member (FM)-A on 7/4/23, this form did not indicate the use of any device. During observation and interview on 7/17/23 at 5:53 p.m., R177 stated "this alarm makes me feel like I am in jail. The alarm sounds as soon as I moved and it's so loud." During interview on 07/18/23 at 12:26 p.m., registered nurse (RN)-B stated a nurse needed to call the family to get consent to use an alarm and obtained an order from the provider. During interview on 7/18/23 at 1:40 p.m., FM-A stated, staff informed her about moving R177 to a different room but not about the alarm. FM-A stated "a couple days ago I called him [R177] and he didn't answer the phone. I called him [R177] later and he said, earlier I couldn't answer the phone because he couldn't get up because his alarm was going to sound, and it was very noisy". R177 also told (FM)-A, he didn't like the alarm because it was limiting his activity and rehabilitation process. During interview on 7/19/23 at 2:22 p.m. licensed practical nurse (LPN)-B stated the alarms were used for safety related to falls when residents do not use their call lights. LPN-B stated the implementation of alarms was discussed on IDT (interdisciplinary team) meetings and the provider and family were updated. LPN-B verified the existence of a nurse order for alarm was dated 7/15/23, and there was lack of documentation	F 553	practice does not recur: Physical devices policy reviewed and updated to ensure facility process meets the regulation. Licensed nurse will complete a physical device assessment in the Assessment section of the electronic health record prior to implementation of a tab alarm. Licensed nurse will obtain consent and doctor□s order for physical device. Licensed nurses and certified nursing assistants will be re-educated to the revised policy. Required monitoring to ensure deficient practice will not recur: The nurse coordinator / designee will audit completion of physical device assessment each time a tab alarm device is initiated, to ensure plan of care development occurred with the patient / responsible party. The frequency of audit is as follows: 3 audits weekly for 1 month. Audit findings to be reported to the QAPI committee monthly to be reviewed and revised according to our QAPI process. Person Responsible: Director of Nursing	

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F 553	Continued From page 4 about contacting the provider or the family. During interview on 7/20/23 at 10:00 a.m., the director of nursing (DON) stated the nurses are expected to implement alarms based on resident's safety to prevent falls when residents are confused. DON stated her expectation was that nurses will implement alarms after they talk to the family and provider. DON also stated, when alarms were implemented during the night, the family and providers should be updated the next day. A copy of the facility's alarms policy and procedure was requested and it was not provided.	F 553		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a significant change in status Minimum Data Set (MDS; i.e., comprehensive assessment) was completed in a	F 637	Deficient practice identified: The facility failed to ensure a significant change in status Minimum Data Set (MDS, i.e., comprehensive assessment) was	9/8/23

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F 637	Continued From page 5 timely manner after hospice services (i.e., end-of-life) were initiated for 1 of 1 resident (R8) reviewed for hospice care. Findings include: The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, identified a comprehensive MDS assessment included completion of the MDS along with the corresponding Care Area Assessment (CAA) and subsequent care planning. The manual outlined such MDS(s) included admission, annual, significant change in status (SCSA), and significant correction to prior comprehensive MDS(s). A table was provided to demonstrated the time periods allowed for such assessments to be completed. This identified a SCSA should have a reference date established within 14 days of determining a significant change has occurred. Further, a section labeled, "Significant Change in Status Assessment (SCSA)," outlined such assessment must be completed when the interdisciplinary team (IDT) has determined a resident meets the criteria for a major improvement or decline adding, "A SCSA is required to be performed with a terminally ill resident enrolls in a hospice program ... The ARD [assessment reference date] must be within 14 days from the effective date of the hospice election ... A SCSA must be performed regardless of whether an assessment was recently conducted on the resident." R8's admission MDS, dated 6/13/23, identified R8 admitted to the transitional care unit (TCU) on 6/6/23 from an acute care hospital, and active discharge planning was in place. The MDS	F 637	completed in a timely manner after hospice services were initiated for 1 resident (R8). Corrective action(s) accomplished for those patients found to have been affected by the deficient practice: Significant Change MDS was completed and submitted immediately for R8. Corrective action taken to identify other patients having the potential to be affected by the same deficient practice: Facility audit performed. Significant change MDS completed in a timely manner for all other patients after hospice services were initiated while in facility. Systematic change(s) to ensure deficient practice does not recur: Skilled nursing assessment policy reviewed and updated to ensure facility process meets regulation. Two licensed nurses will verify a significant change MDS is posted in the MDS schedule after hospice services are initiated. The MDS nurse will document significant change MDS assessment date in patient electronic health record. MDS nurses will be re-educated on the revised policy. Required monitoring to ensure deficient practice will not recur: The Director of Nursing / designee will audit electronic health record of all hospice patients for documentation of	

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F 637	Continued From page 6 section labeled, "Section O - Special Treatments and Programs," outlined treatments and programs, including hospice care, to be selected and indicated on the MDS. This was marked, "Z. None of the above." However, R8's Facility Notification of Hospice Admission/Change, dated 6/27/23, identified R8 admitted to a Medicare-certified hospice agency on 6/27/23, with a "routine" level of care expected. The form was signed and dated 6/27/23, by both hospice and TCU staff members. R8's electronic medical record (EMR) MDS listing, printed 7/18/23, identified the completed, pending, and submitted MDS' for R8 while at the TCU. The last completed or in-progress MDS was the admission MDS (dated 6/13/23). There was no evidence a SCSA had been initiated or completed despite R8 starting hospice care on 6/27/23 (over 14 days prior). On 7/18/23 at 10:02 a.m., registered nurse (RN)-C was interviewed and stated they helped complete the MDS for the TCU campus. RN-C reviewed R8's medical record and verified a SCSA had not been initiated or completed despite R8 electing to sign on with hospice care. RN-C stated a SCSA should have been initiated and completed on 7/11/23, per the RAI manual adding they would schedule it now. RN-C stated they were aware R8 had elected to receive hospice care and expressed they had just missed the SCSA. However, RN-C expressed it was important to ensure SCSA were completed timely as they help ensure the care plan is updated to "reflect what is currently happening" with the resident' care.	F 637	assessment date and completion of significant change MDS. The frequency of audit is as follows: 1x bi-weekly for 1 month. Audit findings to be reported to the QAPI committee monthly to be reviewed and revised according to our QAPI process. Date of correction: 9/8/23 Person Responsible: Director of Nursing	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 7 A facility policy on MDS completion was requested, however, none was received.	F 637		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic medication to help facilitate person-centered care planning for 1 of 5 residents (R71); and ensure parameters for administration of high blood pressure medication were assessed and	F 757	Deficient practice identified: The facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN)narcotic medication to help facilitate person-centered care planning for 1 resident (R71); and ensure parameters for administration of high	9/8/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	C 07/20/2023

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F 757	Continued From page 8 implemented, if needed, for 1 of 5 residents (R7) reviewed for unnecessary medication use. Findings include: R71's Order Summary Report, signed 7/14/23, identified R71 admitted to the transitional care unit (TCU) on 6/28/23, and had several medical diagnoses including end-stage renal disease (ESRD), type I diabetes, and chronic heart failure. The report outlined R71's current physician ordered medications which included Tylenol 975 milligrams (mg) by mouth three times a day, and, "oxyCODONE [a narcotic] ... 5 MG ... 1 tablet by mouth every 6 hours as needed for moderate to severe pain," with a listed start date of 6/28/23. R71's most recent Pain Tool, dated 7/3/23, identified R71 had pain in her left hip rated at "5" on a 0-10 scale FACES scale. The tool outlined, "What makes the pain better?[,]" which was answered with writing, "resting not moving." A section listed, "Medications/Treatments/Modalities," outlined a section prefaced, "Describe all methods of alleviating pain and their effectiveness," which was answered, "resting, tylenol, pain medication." There were no other assessed or recorded non-pharmacological interventions identified to attempt for R71 prior to giving PRN pain medication. R71's completed corresponding Pain Interview, dated 7/3/23, identified R71 had reported pain or hurting within the past five days describing it as occurring, "Frequently," and having made it harder to sleep at night, at times. A pain rating of "5" was recorded, and a section listed, "Pain Management," outlined options to be selected for	F 757	blood pressure medication were assessed and implemented, if needed, for 1 resident (R7). Corrective action(s) accomplished for those patients found to have been affected by the deficient practice: R71 discharged from facility on 7/18/23. Corrective action taken to identify other patients having the potential to be affected by the same deficient practice: Facility chart audit performed. Non-pharmalogical interventions for as-needed narcotic pain medication documented in progress note section each shift for all other patients. Education provided to nurses about offering non-pharmalogical intervention(s) prior to medication administration and to document under order section. Systematic change(s) to ensure deficient practice does not recur: Medication management policy reviewed and updated to ensure facility process meets regulation. Vital signs policy reviewed and updated to ensure facility process meets regulation. Licensed nurse must attempt and offer non-pharmalogical intervention(s) prior to administration of PRN narcotic pain medication. Licensed nurse will document non-pharmalogical intervention(s) under the PRN narcotic pain medication order in the electronic medical record (EMAR) section.	

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F 757	Continued From page 9 corresponding pain interventions. This section outlined R71 received scheduled and PRN pain medication including tylenol and oxycodone. However, the response provided reading, "Received non-medication intervention for pain?[,]" was left unchecked but with dictation recorded reading, "resting, ice and not moving." R71's Medication Administration Record (MAR), dated 7/2023, identified the physician orders and treatments with corresponding spaces to record their administration via staff initials. The MAR listed R71's order for the as-needed oxycodone, along with dictation showing multiple doses were administered including: On 7/1/23 at 4:09 p.m., with a recorded pain rating of 5/10 and the results of administration being listed as, "I [ineffective]." A corresponding progress note, dated 7/1/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. On 7/4/23 at 10:44 p.m., with a recorded pain rating of 5/10 and the results of the administration being listed as, "E [effective]." A corresponding progress note, dated 7/4/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. On 7/11/23 at 4:22 p.m., with a recorded pain rating of 6/10 and the results of the administration being listed as, "E." A corresponding progress note, dated 7/11/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior.	F 757	Licensed nurses and trained medication aides will be re-educated on the revised policies. Required monitoring to ensure deficient practice will not recur: The nurse coordinator / designee will audit patient electronic health records to ensure non-pharmalogical interventions are attempted, offered, and documented prior to PRN medication administration. The frequency of audit is as follows: 3x weekly for 1 month. Audit findings to be reported to the QAPI committee monthly to be reviewed and revised according to our QAPI process. Date of correction: 9/8/23 Person Responsible: Director of Nursing	

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F 757	Continued From page 10 On 7/15/23 at 4:28 p.m., with a recorded pain rating of 6/10 and the results of the administration being listed as, "E." A corresponding progress note, dated 7/15/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. On 7/16/23 at 5:00 p.m., with a recorded pain rating of 7/10 and the results of the administration being listed as, "I." A corresponding progress note, dated 7/16/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. The MAR recorded a total of five administrations of the PRN narcotic medication with none of them having recorded non-pharmacological interventions offered, attempted or refused prior to the administration despite ice application being identified on the completed Pain Interview (dated 7/3/23) as potentially effective for R71. When interviewed on 7/18/23 at 11:30 a.m., registered nurse (RN)-A explained R71 used oxycodone but "hardly ever" to their recall. RN-A stated when PRN narcotic pain medication, the staff should be assessing if the reported pain was new or chronic and, depending on the pain rating, giving non-narcotic medication (i.e., Tylenol) prior, if able. If the pain was severe, then the PRN narcotic could be given. However, RN-A verified staff were to attempt and document non-pharmacological interventions (i.e., ice, repositioning) prior to giving such medication adding they "should be recorded in the progress note." RN-A verified even refused	F 757		

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F 757	Continued From page 11 non-pharmacological interventions were expected to be recorded adding, "If you didn't chart it, it didn't happen." During interview on 7/19/23 at 12:12 p.m., the consulting pharmacist (CP) expressed patient specific non-pharmacological interventions should be attempted and recorded in the medical record before PRN medications, including anti-psychotics, were given. This was done so staff know what does and does not work to help the patient and to help reduce the risk of unnecessary medication doses. On 7/19/23 at 1:42 p.m., licensed practical nurse unit manager (LPN)-A was interviewed. LPN-A verified they had reviewed R71's medical record and explained R71's completed Pain Tool/Interview (dated 7/3/23) outlined non-pharmacological interventions which could be attempted. LPN-A stated R71 was also on pain monitoring every shift and acknowledged nurses were expected to offer and, if able, provide non-pharmacological interventions prior to giving PRN narcotic medication. LPN-A stated they had not noticed any concerns with such interventions being completed in day-to-day care of R71, however, verified the lack of documentation supporting such adding, "If [staff] didn't chart it, [staff] didn't do it." LPN-A stated it was important to ensure non-pharmacological interventions were attempted to recorded prior to giving PRN narcotic medication to help ensure the resident remains on the medication for as short amount of time as possible. R7's admission Minimum Data Set (MDS), dated	F 757		

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F 757	Continued From page 12	F 757		

4/19/23, indicated R7 had moderate cognitive impairment and needed extensive assistance with most activities of daily living (ADLs).

R7's Physician Orders, dated 4/13/23, indicated R7 had an order for Metoprolol Succinate (an anti-hypertensive medication) Extended Release, 150 milligram (mg) tablet once a day. The order lacked any evidence of parameters on when to hold the medication and lacked any order to monitor blood pressure prior to administration.

R7's vital signs indicated R7 had multiple episodes of systolic blood pressure readings of less than 100 millimeters (mm)/mercury(hg) in the past 30 days.

During observation on 07/18/23 at 8:15 a.m., trained medication assistant (TMA)-A administered R7 his Metoprolol without checking R7's blood pressure and confirmed there were no prompts in the medication administration record (MAR) to check R7's blood pressure prior to medication administration or parameters on when to hold the medication.

During an interview on 7/19/23 at 10:10 a.m., licensed practical nurse (LPN)-B stated the expectation was for the nurses and TMAs to monitor blood pressure and pulse prior to administering any anti-hypertensive medication. LPN-B stated she would expect to to see a physician order with parameters on when to hold the medication. LPN-B further stated it would be expected for the nurses to follow up with the physician on a antihypertensive medication that did not have parameters.

During an interview on 7/19/23 at 12:12 p.m., the

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F 757	Continued From page 13 consultant pharmacist (CP) stated she would expect blood pressure to be taken frequently on a resident who had variations in blood pressure, being high or low readings. After reviewing R7's frequent low blood pressure readings and lack of blood pressure monitoring prior to administration of medications, the CP stated monitoring R7's blood pressure prior to administering medications was something she would "definitely make note of and look into." A policy on monitoring blood pressure medication was requested but not received.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		9/8/23

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F 758	Continued From page 14 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) anti-psychotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., sedation) for 1 of 5 residents (R76) reviewed for unnecessary medication use. Findings include: R76's Order Summary Report, signed 7/18/23,	F 758	Deficient practice identified: The facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) anti-psychotic medication to help facilitate person-centered care planning and reduce the risk of complication (i.e., sedation) for 1 resident (R76). Corrective actions(s) accomplished for those patients found to have been affected by the deficient	

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F 758	Continued From page 15 identified R76 admitted to the transitional care unit (TCU) on 7/12/23, and had several medical diagnoses including heart failure and Alzheimer's Disease. The report outlined R76's current physician ordered medications which included, "SEROquel [an anti-psychotic medication] Oral Tablet 25 MG [milligrams] ... by mouth every 8 hours as needed for agitation ...," with a listed start date of 7/18/23. On 7/17/23 at approximately 1:00 p.m., R76 was observed seated on the bedside while in his room. R76 was unable to answer how long he had been at the TCU, and repeatedly asked the surveyor if they were working on "the contracts." R76 appeared in no acute distress, was well-groomed and without obvious physical signs or symptoms of pain. R76's Medication Administration Record (MAR), dated 7/2023, identified the physician orders and treatments with corresponding spaces to record their administration via staff initials. The MAR listed R76's order for the as-needed Seroquel, along with dictation showing a total of five doses were administered including: On 7/13/23 at 7:18 p.m., with the results being recorded as, "I [ineffective]." A corresponding progress note, dated 7/13/23, identified the medication was given, however, the note lacked any specific recorded symptoms displayed which warranted the medication nor what, if any, non-pharmacological interventions were attempted prior to giving the medication. A subsequent note, dated 7/13/23, identified R76 was confused, self transferring and wandering through the unit. The note outlined, "Attempted to administer prn seroquel [sic], resident spit it out	F 758	practice: Nurses re-educated to attempt and offer non-pharmalogical intervention(s) prior to administration of anti-psychotic medication. Nurses re-educated to document non-pharmalogical intervention(s) under the order in the electronic medical record (EMAR) section. R76 discharged from facility on 7/21/23. Corrective action taken to identify other patients having the potential to be affected by the same deficient practice: Facility chart audit performed. Non-pharmalogical interventions for anti-psychotic medication documented in progress note section each shift for all other patients. Education provided to nurses about offering non-pharmalogical intervention(s) prior to medication administration and documentation of intervention under order section. Systematic change(s) to ensure deficient practice does not recur: Psychotropic medication policy reviewed and updated to ensure facility process meets regulation. Licensed nurse must attempt and offer non-pharmalogical intervention(s) prior to administration of PRN anti-psychotic medication. Licensed nurse will document non-pharmalogical intervention(s) under the PRN anti-psychotic medication order in the electronic medical record (EMAR) section. Licensed nurses and trained medication aides will be re-educated on the revised	

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F 758	Continued From page 16 after administration. Walked with resident around unit with gait belt and FWW [walker]." However, again, the note lacked what non-pharmacological interventions had been attempted prior to giving the medication. On 7/14/23 at 7:16 p.m., with results being recorded as, "E [effective]." A corresponding progress note, dated 7/14/23, identified the medication was given, however, lacked any specific recorded symptoms displayed which warranted the medication nor what, if any, non-pharmacological interventions were attempted prior to giving the medication. Further, there were no other recorded progress notes around this time which outlined what, if any, behaviors were displayed or what, if any, non-pharmacological interventions had been attempted prior to giving the medication. On 7/16/23 at 4:57 p.m., with results being recorded as, "I." A corresponding progress note, dated 7/16/23, identified the medication was given, however, lacked any specific recorded symptoms displayed which warranted the medication nor what, if any, non-pharmacological interventions were attempted prior to giving the medication. Further, there were no other recorded progress notes around this time which outlined what, if any, behaviors were displayed or what, if any, non-pharmacological interventions had been attempted prior. On 7/18/23 at 7:00 p.m., with results being recorded as, "E." A corresponding progress note, dated 7/18/23, identified the medication was given, however, lacked any specific recorded symptoms displayed which warranted the medication nor what, if any, non-pharmacological	F 758	policy. Required monitoring to ensure deficient practice will not recur: The nurse coordinator / designee will audit patient electronic health records to ensure non-pharmalogical interventions are attempted, offered, and documented prior to PRN medication administration. The frequency of audit is as follows: 3x weekly for 1 month. Audit findings to be reported to the QAPI committee monthly to be reviewed and revised according to our QAPI process. Date of correction: 9/8/23 Person Responsible: Director of Nursing	

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F 758	Continued From page 17	F 758		

interventions were attempted prior to giving the medication. Further, there were no other recorded progress notes around this time which outlined what, if any, behaviors were displayed or what, if any, non-pharmacological interventions had been attempted prior.

In total, four of the five administered doses had no recorded specific behavioral symptoms which demonstrated the rationale for giving the PRN Seroquel; nor any evidence of what, if any, non-pharmacological interventions had been attempted prior to the medication being given. The medical record was reviewed and lacked evidence of what, if any, non-pharmacological interventions had been attempted prior to each recorded administration.

On 7/19/23 at 10:45 a.m., registered nurse (RN)-A was interviewed. RN-A explained they had only worked with R76 a few times and described him as "not oriented," adding R76 had been wandering into other resident' rooms earlier in the week. RN-A explained the process when giving a PRN medication, including an antipsychotic medication, included assessing the resident for prior history with use of the medication as the medications could cause drowsiness or even "more agitation" if they've never had them prior. RN-A verified non-pharmacological interventions were supposed to be attempted and recorded in the progress notes with any PRN antipsychotic medication administration, however, added such "doesn't always happen." RN-A added, "We know we need to chart."

When interviewed on 7/19/23 at 12:12 p.m., the consulting pharmacist (CP) stated patient specific non-pharmacological interventions should be

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F 758	Continued From page 18 attempted and recorded in the medical record before PRN medications, including anti-psychotics, were given. This was done so staff know what does and does not work to help the patient and to help reduce the risk of unnecessary medication doses. On 7/20/23 at 8:56 a.m., licensed practical nurse unit manager (LPN)-A was interviewed and verified they had reviewed R76's medical record. LPN-A acknowledged several of the recorded PRN Seroquel doses lacked evidence of any non-pharmacological interventions being attempted prior, however, voiced they did see them being done in day-to-day activities with R76. However, LPN-A verified the PRN Seroquel doses should have had non-pharmacological interventions charted when they were given. A provided Medication Management policy, dated 5/2022, identified a procedure of providing medication to residents at the care center. This instructed a licensed nurse must approve any TMA (trained medication aide) to provide PRN medication "after completing an assessment." The policy continued and directed when a PRN medication was provided the date, time, dose, route of administration, complaint or symptoms for the medication, and results from it, were to be documented in the medical record. However, the policy lacked any information or guidance on the use and documentation needs of non-pharmacological interventions prior to use of PRN medication.	F 758		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services.	F 790		9/8/23

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	245618	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 790	Continued From page 19 The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by:	F 790		

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F 790	Continued From page 20 Based on interview and document review, the facility failed to ensure assessed oral and dental abnormalities were acted upon and, if needed or desired, referred to a dental provider to reduce the risk of complication (i.e., further breakdown, oral pain) for 1 of 2 residents (R8) reviewed for dental hygiene and services. Findings include: R8's admission Minimum Data Set (MDS), dated 6/13/23, identified R8 admitted to the transitional care unit (TCU) on 6/6/23 from the acute care hospital and had moderate cognitive impairment. Further, the MDS, under section L0200, recorded R8 had no dental concerns (i.e., broken teeth, obvious cavities) with the selected option, "None of the above were present." R8's Census listing, printed 7/18/23, identified R8's payer sources since admission. This included, "Medicare A," from 6/6/23 to 6/27/23 when R8 became, "Private Pay." On 7/17/23 at 1:05 p.m., R8 was interviewed and expressed she had dental concerns. R8 explained she wore a full upper denture and partial lower denture, however, the few remaining natural teeth "are breaking apart" and she needed to get seen by the dentist. R8 stated she had planned to have it addressed while she lived in the assisted living facility (ALF) but then "this all came about [illness]," which caused her to move to the transitional care unit (TCU) and need more long-term care. R8 stated, as a result of her teeth condition, she had to consume a ground-up diet and had issues with chewing. Further, R8 stated nobody from the nursing home had discussed what, if any, dental options were available in or	F 790	Deficient practice identified: The facility failed to ensure assessed oral and dental abnormalities were acted upon and, if needed or desired, referred to a dental provider to reduce the risk of complication (i.e., further breakdown, oral pain) for 1 resident (R8). Corrective action(s) accomplished for those patients found to have been affected by the deficient practice: Oral assessment performed by the nurse on 7/18/23 and no loose or broken teeth noted. R8 denies pain and/or difficulty chewing and eating. R8 seen by registered dental hygienist at facility on 7/19/23 and noted loose fitting dentures but no reports of pain. Family aware of dentures and does not feel it is a concern for R8 unless someone brings it up to her. R8 has dementia and has not report pain or difficulty eating to family. R8 on hospice and family has declined follow up with dentist currently. Corrective action taken to identify other patients having the potential to be affected by the same deficient practice: Facility chart audit performed. Initial oral assessments and oral care plan completed for all other patients. Systematic change(s) to ensure deficient practice does not recur: Dental services policy reviewed and updated to ensure facility process meets regulation. Licensed nurse will complete an oral	

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F 790	Continued From page 21 through the TCU despite admitting to the care venue nearly a month prior. R8's Nursing Assessment - Admission/Readmission + (plus) Careplan - V13, dated 6/6/23, identified R8 was alert and oriented to person, place, time, and situation. A section labeled, "Oral, Vision and Hearing Status," which outlined R8 used dentures but also had, "Loose, Broken Teeth, or Tooth Fragments." A section was listed, "Last Dental Visit," however, this space was left blank and no data was written. Further, the corresponding options to identify what, if any, care planning would be completed for R8's dental and/or oral condition were all left unchecked and not completed. However, R8's medical record was reviewed and lacked evidence the identified potential abnormalities with R8's teeth identified upon the admission evaluation (dated 6/6/23) had been acted upon or assessed, including for any desired dental care or services, despite R8 initially admitting to the TCU over a month prior. When interviewed on 7/18/23 at 10:45 a.m., nursing assistant (NA)-A stated they had worked with R8 several times, and described R8 as being accepting of cares and having "OK" cognition. NA-A stated R8 wore dentures and only needed set-up and cues for oral cares. Further, NA-A stated R8 had not complained about her teeth prior and had no dental concerns to their knowledge adding, "They're [teeth] good." On 7/18/23 at 11:43 a.m., registered nurse (RN)-A was interviewed. RN-A stated R8 admitted awhile ago to the TCU and recently elected to receive hospice care and services. RN-A	F 790	assessment and oral care plan during the initial nursing assessment. Licensed nurse will communicate abnormalities identified to patient / responsible party for development of care plan, including dentist follow up if indicated. Licensed nurse will document abnormalities identified and dental plan in the oral assessment. Licensed nurse will notify health unit coordinator about follow up of initial dental examination, if indicated. Licensed nurses and health unit coordinators will be re-educated on the revised policy. Required monitoring to ensure deficient practice will not recur: The nurse coordinator / designee will audit patient electronic health records to ensure that initial oral assessment, oral care plan, and dental plan are completed and recorded. The frequency of audit is as follows: 3x weekly for 1 month. Audit findings to be reported to the QAPI committee monthly to be reviewed and revised according to our QAPI process. Date of correction: 9/8/23 Person Responsible: Director of Nursing	

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F 790	Continued From page 22 explained dental status and condition was assessed upon admission and, if needed, a patient could be referred to the onsite dental program (i.e., dental hygienist) for care. RN-A stated they were unaware if R8 had any dental issues or concerns, nor if R8 had been offered or refused dental services adding, "I don't believe so." On 7/18/23 at 1:47 p.m., licensed social worker (LSW)-A and the licensed practical nurse unit manager (LPN)-A were interviewed. LSW-A explained R8 had several previous admissions to the TCU and, prior to this current admission, lived in the attached ALF but came to the TCU after a hospitalization and, since then, has needed more long-term care needs and hospice services. LPN-A explained R8 had been admitted to the TCU on a previous stay (2023) and, at that time, had been seen by the dental hygienist and provided their completed evaluation for review. R8's corresponding Dental Evaluation - V3, dated 4/18/23, identified R8 was unable to answer or report when their last dental examination was completed, and had a checkmark placed next to the option which read, "Mouth or facial pain, discomfort or difficulty with chewing." The evaluation outlined R8 wore full upper and lower partial dentures, had visible "slight" deposits of plaque on their remaining natural teeth with another checkmark being placed next to, "Broken or loosely fitting full or partial denture ..." A section labeled, "Recommended Treatments, Careplan Recommendations, and Referrals," directed R8 had "mild issues present" and no referral to the dental clinic was made. The evaluation concluded with a notes section which outlined, "The Oral Health Program did an oral assessment ... does	F 790		

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F 790	Continued From page 23 not eat hard foods because her upper denture is loose ... lost lower partial denture ... states she is going to go to her dentist after she is discharged ... [been] several years since her last dental visit ... " The interview continued, and LPN-A stated they had just prior followed up with R8 who denied oral pain but endorsed difficulty chewing with harder foods and, as a result, was just placed on the list to be seen by the onsite dental hygienist who came to the TCU "once or twice a week," typically. LPN-A stated dental visits, and the need for such visits, should be recorded on the admission examination (i.e., Nursing Assessment - Admission/Readmission; dated 6/6/23) and felt the space being left blank, such as with R8's assessment, likely meant the last examination was unknown. LSW-A stated this conversation was their "first time hearing about it [dental issues]." LPN-A acknowledged the medical record lacked evidence the identified concerns outlined on R8's current admission evaluation (dated 6/6/23) had been acted upon or addressed for potential further care needs, and expressed it was important to ensure dental needs were addressed timely to reduce the risk of oral infection and "all that." Further, LSW-A stated R8 had cognitive impairment and was "not totally reliable," adding they felt if R8's family had been concerned with R8's dentition then they would have reached out and expressed it. However, LSW-A and LPN-A both acknowledged R8's cognitive impairment made relevant ensuring appropriate follow-up was offered, documented in the record and, if needed or wanted, provided to them. On 7/18/23 at 2:39 p.m., the director of nursing	F 790		

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F 790	Continued From page 24 (DON) was interviewed and R8's dental concerns were discussed. DON stated the facility had not yet completed R8's significant change MDS when she elected to sign up for hospice (on 6/27/23; see F637) and, had the assessment been completed, then R8's dental status and needs would have likely been identified and addressed timely with her transition to more long-term care. A provided Dental Services policy, dated 2/2020, identified the facility would provide or obtain routine dental services to meet each resident' need. A procedure was listed which outlined an initial nursing assessment would be completed at the time of each resident' admission to the community, and within 90 days of admission a resident needed to be referred for an initial dental examination unless one had been completed within the past six months prior. However, the policy lacked information on what, if any, process changes would be done if abnormalities were identified on the initial nursing evaluation (i.e., modify or accelerate the process).	F 790		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		9/8/23

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F 883	Continued From page 25 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

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F 883	Continued From page 26 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R2, R7) were offered or received the pneumococcal pneumonia vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R2's admission Minimum Data Set (MDS), dated 7/2/23, indicated R2 was admitted to the facility on 7/2/2. Based on interview, R2 appeared to be cognitively intact. R2's immunization record indicated R2 had receive the Pneumococcal PCV13 vaccine on 9/26/16 but lacked evidence of R2 receiving, or being offered, the pneumococcal PCV20 or PPSV23 vaccine per CDC recommendations. During interview on 7/20/23 at 10:45 a.m., R2 stated she was not offered any vaccines when she was admitted to the facility. R7's (MDS), dated 4/19/23, indicated R7 was admitted to the facility on 4/12/23 and had moderate cognitive impairment. R7's immunization record indicated R7 had receive the Pneumococcal PCV13 vaccine on 1/3/22 but lacked evidence of R2 receiving, or being offered, the pneumococcal PCV20 or PPSV23 vaccine per CDC recommendations. During interview on 7/20/23 at 10:46 a.m., R7	F 883	Deficient practice identified: The facility failed to ensure 2 residents (R2, R7) were offered or received the pneumococcal pneumonia vaccine in accordance with the Center for Disease Control (CDC)recommendations. Corrective action(s) accomplished for those patients found to have been affected by the deficient practice: The nurse offered R2 and R7 the pneumococcal pneumonia vaccine. R2 decline and will follow up with primary care provider. R7 decline due to upcoming surgery. R2 discharged from facility on 8/2/23. Corrective action taken to identify other patients having the potential to be affected by the same deficient practice: Facility chart audit performed. Pneumococcal pneumonia vaccine offered or received for all other patients. Systematic change(s) to ensure deficient practice does not recur: Pneumococcal vaccine policy reviewed and updated to ensure facility process meets regulation. Licensed nurse will offer and complete pneumococcal pneumonia vaccine consent/declination form on day 3 of admission but no later than day 7 of admission.	

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F 883	Continued From page 27 stated he did not remember if he was offered any vaccines when he was admitted to the facility. During an interview on 7/19/23 at 9:27 a.m., the infection control preventionist (ICP) stated when a resident admitted to the facility she would review the Minnesota Immunization Information Connection (MIIC) and update a spreadsheet with the residents' current vaccination status. The ICP would then send the spreadsheet to the nurse managers for review and follow up. During an interview 7/19/23 at 10:10 a.m., licensed practical nurse (LPN)-B stated the expectation was to review a resident's immunization status and offer any needed vaccines upon admission. LPN-B further stated a refusal of a vaccine should be documented in the resident's electronic medical record (EMR). LPN-B confirmed the facility had access to the pneumococcal PPSV 23 vaccine if needed. LPN-B reviewed R2's and R7's EMR and confirmed their pneumococcal vaccines were not up to date, lacked documentation of being offered, and a refusal was not documented. A policy on immunizations was requested and not received.	F 883	Infection control preventionist and licensed nurses will be re-educated on the revised policy. Required monitoring to ensure deficient practice will not recur: The infection control preventionist / designee will audit patient electronic health records to ensure that pneumococcal pneumonia vaccine offered, received, and recorded. The frequency of audit is as follows: 3x weekly for 1 month. Audit findings to be reported to the QAPI committee monthly to be reviewed and revised according to our QAPI process. Date of correction: 9/8/23 Person Responsible: Director of Nursing	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/17/23 to 7/20/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Walker Methodist Westwood Ridge II was found not in compliance with the MN State Licensure, and the following	2 000		

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2 000	Continued From page 1 correction orders were issued. The following complaints were reviewed during the survey: H56183540C (MN00088569) H56183541C (MN00087708) H56183622C (MN00091712) H56183623C (MN00089508) H56183624C (MN00084960) Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. MDH is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide an opportunity for participation in care plan development for 1 of 1 resident (R177) reviewed for participation in care planning.	2 555	Corrected	9/8/23

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	27996	A. BUILDING: _____ B. WING _____	C 07/20/2023

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WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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2 555	Continued From page 3 Findings included: R177's Admission Record dated 7/21/23, indicated R177 was admitted to the facility on 7/4/23. R177's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/23, indicated R177 was cognitively intact, had no behaviors or mood concerns, and indicated it was very important to have family involved in discussions about care. The MDS indicated, R177 needed assistance of one staff member with transfer, ambulation, bathing, and dressing. Diagnoses included progressive neurological condition, reaction due to neurostimulator implant of the brain, hypertension, diabetes mellitus, non-Alzheimer's dementia and Parkinson's (a disorder of the central nervous system that affects movement, often including tremors) disease. R177's Order Summary Report included a nursing order dated 7/15/23, "Tabs alarm placed for safety; ensure plugged in and functioning q [every] shift." R177's Care Plan created 7/4/23, indicated R177 was at risk for falls related to Parkinson's disease and directed staff to anticipate R177's needs, to be sure the call light was within reach and to encourage R177 to use it for assistance as needed. R177's Physical Devices Consent was signed by R117's family member (FM)-A on 7/4/23, this form did not indicate the use of any device. During observation and interview on 7/17/23 at	2 555		

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2 555	Continued From page 4 5:53 p.m., R177 stated "this alarm makes me feel like I am in jail. The alarm sounds as soon as I moved and it's so loud." During interview on 07/18/23 at 12:26 p.m., registered nurse (RN)-B stated a nurse needed to call the family to get consent to use an alarm and obtained an order from the provider. During interview on 7/18/23 at 1:40 p.m., FM-A stated, staff informed her about moving R177 to a different room but not about the alarm. FM-A stated "a couple days ago I called him [R177] and he didn't answer the phone. I called him [R177] later and he said, earlier I couldn't answer the phone because he couldn't get up because his alarm was going to sound, and it was very noisy". R177 also told (FM)-A, he didn't like the alarm because it was limiting his activity and rehabilitation process. During interview on 7/19/23 at 2:22 p.m. licensed practical nurse (LPN)-B stated the alarms were used for safety related to falls when residents do not use their call lights. LPN-B stated the implementation of alarms was discussed on IDT (interdisciplinary team) meetings and the provider and family were updated. LPN-B verified the existence of a nurse order for alarm was dated 7/15/23, and there was lack of documentation about contacting the provider or the family. During interview on 7/20/23 at 10:00 a.m., the director of nursing (DON) stated the nurses are expected to implement alarms based on resident's safety to prevent falls when residents are confused. DON stated her expectation was that nurses will implement alarms after they talk to the family and provider. DON also stated, when alarms were implemented during the night, the	2 555		

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2 555	Continued From page 5 family and providers should be updated the next day. A copy of the facility's alarms policy and procedure was requested and it was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on care plan development for assessed resident' needs; then educate staff to ensure completion and knowledge; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 555		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21325	Corrected	9/8/23

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21325	Continued From page 6 facility failed to ensure assessed oral and dental abnormalities were acted upon and, if needed or desired, referred to a dental provider to reduce the risk of complication (i.e., further breakdown, oral pain) for 1 of 2 residents (R8) reviewed for dental hygiene and services. Findings include: R8's admission Minimum Data Set (MDS), dated 6/13/23, identified R8 admitted to the transitional care unit (TCU) on 6/6/23 from the acute care hospital and had moderate cognitive impairment. Further, the MDS, under section L0200, recorded R8 had no dental concerns (i.e., broken teeth, obvious cavities) with the selected option, "None of the above were present." R8's Census listing, printed 7/18/23, identified R8's payer sources since admission. This included, "Medicare A," from 6/6/23 to 6/27/23 when R8 became, "Private Pay." On 7/17/23 at 1:05 p.m., R8 was interviewed and expressed she had dental concerns. R8 explained she wore a full upper denture and partial lower denture, however, the few remaining natural teeth "are breaking apart" and she needed to get seen by the dentist. R8 stated she had planned to have it addressed while she lived in the assisted living facility (ALF) but then "this all came about [illness]," which caused her to move to the transitional care unit (TCU) and need more long-term care. R8 stated, as a result of her teeth condition, she had to consume a ground-up diet and had issues with chewing. Further, R8 stated nobody from the nursing home had discussed what, if any, dental options were available in or through the TCU despite admitting to the care venue nearly a month prior.	21325		

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21325	Continued From page 7 R8's Nursing Assessment - Admission/Readmission + (plus) Careplan - V13, dated 6/6/23, identified R8 was alert and oriented to person, place, time, and situation. A section labeled, "Oral, Vision and Hearing Status," which outlined R8 used dentures but also had, "Loose, Broken Teeth, or Tooth Fragments." A section was listed, "Last Dental Visit," however, this space was left blank and no data was written. Further, the corresponding options to identify what, if any, care planning would be completed for R8's dental and/or oral condition were all left unchecked and not completed. However, R8's medical record was reviewed and lacked evidence the identified potential abnormalities with R8's teeth identified upon the admission evaluation (dated 6/6/23) had been acted upon or assessed, including for any desired dental care or services, despite R8 initially admitting to the TCU over a month prior. When interviewed on 7/18/23 at 10:45 a.m., nursing assistant (NA)-A stated they had worked with R8 several times, and described R8 as being accepting of cares and having "OK" cognition. NA-A stated R8 wore dentures and only needed set-up and cues for oral cares. Further, NA-A stated R8 had not complained about her teeth prior and had no dental concerns to their knowledge adding, "They're [teeth] good." On 7/18/23 at 11:43 a.m., registered nurse (RN)-A was interviewed. RN-A stated R8 admitted awhile ago to the TCU and recently elected to receive hospice care and services. RN-A explained dental status and condition was assessed upon admission and, if needed, a patient could be referred to the onsite dental	21325		

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21325	Continued From page 8 program (i.e., dental hygienist) for care. RN-A stated they were unaware if R8 had any dental issues or concerns, nor if R8 had been offered or refused dental services adding, "I don't believe so." On 7/18/23 at 1:47 p.m., licensed social worker (LSW)-A and the licensed practical nurse unit manager (LPN)-A were interviewed. LSW-A explained R8 had several previous admissions to the TCU and, prior to this current admission, lived in the attached ALF but came to the TCU after a hospitalization and, since then, has needed more long-term care needs and hospice services. LPN-A explained R8 had been admitted to the TCU on a previous stay (2023) and, at that time, had been seen by the dental hygienist and provided their completed evaluation for review. R8's corresponding Dental Evaluation - V3, dated 4/18/23, identified R8 was unable to answer or report when their last dental examination was completed, and had a checkmark placed next to the option which read, "Mouth or facial pain, discomfort or difficulty with chewing." The evaluation outlined R8 wore full upper and lower partial dentures, had visible "slight" deposits of plaque on their remaining natural teeth with another checkmark being placed next to, "Broken or loosely fitting full or partial denture ..." A section labeled, "Recommended Treatments, Careplan Recommendations, and Referrals," directed R8 had "mild issues present" and no referral to the dental clinic was made. The evaluation concluded with a notes section which outlined, "The Oral Health Program did an oral assessment ... does not eat hard foods because her upper denture is loose ... lost lower partial denture ... states she is going to go to her dentist after she is discharged ... [been] several years since her last dental visit	21325		

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21325	Continued From page 9 ..." The interview continued, and LPN-A stated they had just prior followed up with R8 who denied oral pain but endorsed difficulty chewing with harder foods and, as a result, was just placed on the list to be seen by the onsite dental hygienist who came to the TCU "once or twice a week," typically. LPN-A stated dental visits, and the need for such visits, should be recorded on the admission examination (i.e., Nursing Assessment - Admission/Readmission; dated 6/6/23) and felt the space being left blank, such as with R8's assessment, likely meant the last examination was unknown. LSW-A stated this conversation was their "first time hearing about it [dental issues]." LPN-A acknowledged the medical record lacked evidence the identified concerns outlined on R8's current admission evaluation (dated 6/6/23) had been acted upon or addressed for potential further care needs, and expressed it was important to ensure dental needs were addressed timely to reduce the risk of oral infection and "all that." Further, LSW-A stated R8 had cognitive impairment and was "not totally reliable," adding they felt if R8's family had been concerned with R8's dentition then they would have reached out and expressed it. However, LSW-A and LPN-A both acknowledged R8's cognitive impairment made relevant ensuring appropriate follow-up was offered, documented in the record and, if needed or wanted, provided to them. On 7/18/23 at 2:39 p.m., the director of nursing (DON) was interviewed and R8's dental concerns were discussed. DON stated the facility had not yet completed R8's significant change MDS when she elected to sign up for hospice (on 6/27/23; see F637) and, had the assessment been	21325		

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21325	Continued From page 10 completed, then R8's dental status and needs would have likely been identified and addressed timely with her transition to more long-term care. A provided Dental Services policy, dated 2/2020, identified the facility would provide or obtain routine dental services to meet each resident' need. A procedure was listed which outlined an initial nursing assessment would be completed at the time of each resident' admission to the community, and within 90 days of admission a resident needed to be referred for an initial dental examination unless one had been completed within the past six months prior. However, the policy lacked information on what, if any, process changes would be done if abnormalities were identified on the initial nursing evaluation (i.e., modify or accelerate the process). SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review applicable policies on dental assessment and, if needed, appointment coordination to ensure timely and thorough completion; then inservice appropriate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	21325		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug	21535		9/8/23

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21535	Continued From page 11 therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure non-pharmacological interventions were attempted and recorded prior to the administration of as-needed (PRN) narcotic medication to help facilitate person-centered care planning for 1 of 5 residents (R71); and ensure parameters for administration of high blood pressure medication were assessed and implemented, if needed, for 1 of 5 residents (R7) reviewed for unnecessary medication use. Findings include: R71's Order Summary Report, signed 7/14/23, identified R71 admitted to the transitional care unit (TCU) on 6/28/23, and had several medical diagnoses including end-stage renal disease	21535	Corrected	

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21535	Continued From page 12 (ESRD), type I diabetes, and chronic heart failure. The report outlined R71's current physician ordered medications which included Tylenol 975 milligrams (mg) by mouth three times a day, and, "oxyCODONE [a narcotic] ... 5 MG ... 1 tablet by mouth every 6 hours as needed for moderate to severe pain," with a listed start date of 6/28/23. R71's most recent Pain Tool, dated 7/3/23, identified R71 had pain in her left hip rated at "5" on a 0-10 scale FACES scale. The tool outlined, "What makes the pain better?[,]" which was answered with writing, "resting not moving." A section listed, "Medications/Treatments/Modalities," outlined a section prefaced, "Describe all methods of alleviating pain and their effectiveness," which was answered, "resting, tylenol, pain medication." There were no other assessed or recorded non-pharmacological interventions identified to attempt for R71 prior to giving PRN pain medication. R71's completed corresponding Pain Interview, dated 7/3/23, identified R71 had reported pain or hurting within the past five days describing it as occurring, "Frequently," and having made it harder to sleep at night, at times. A pain rating of "5" was recorded, and a section listed, "Pain Management," outlined options to be selected for corresponding pain interventions. This section outlined R71 received scheduled and PRN pain medication including tylenol and oxycodone. However, the response provided reading, "Received non-medication intervention for pain?[,]" was left unchecked but with dictation recorded reading, "resting, ice and not moving." R71's Medication Administration Record (MAR), dated 7/2023, identified the physician orders and	21535		

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21535	Continued From page 13 treatments with corresponding spaces to record their administration via staff initials. The MAR listed R71's order for the as-needed oxycodone, along with dictation showing multiple doses were administered including: On 7/1/23 at 4:09 p.m., with a recorded pain rating of 5/10 and the results of administration being listed as, "I [ineffective]." A corresponding progress note, dated 7/1/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. On 7/4/23 at 10:44 p.m., with a recorded pain rating of 5/10 and the results of the administration being listed as, "E [effective]." A corresponding progress note, dated 7/4/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. On 7/11/23 at 4:22 p.m., with a recorded pain rating of 6/10 and the results of the administration being listed as, "E." A corresponding progress note, dated 7/11/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. On 7/15/23 at 4:28 p.m., with a recorded pain rating of 6/10 and the results of the administration being listed as, "E." A corresponding progress note, dated 7/15/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. On 7/16/23 at 5:00 p.m., with a recorded pain rating of 7/10 and the results of the administration	21535		

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21535	Continued From page 14 being listed as, "I." A corresponding progress note, dated 7/16/23, identified the medication was provided, however, lacked evidence of any non-pharmacological interventions being attempted or offered prior. The MAR recorded a total of five administrations of the PRN narcotic medication with none of them having recorded non-pharmacological interventions offered, attempted or refused prior to the administration despite ice application being identified on the completed Pain Interview (dated 7/3/23) as potentially effective for R71. When interviewed on 7/18/23 at 11:30 a.m., registered nurse (RN)-A explained R71 used oxycodone but "hardly ever" to their recall. RN-A stated when PRN narcotic pain medication, the staff should be assessing if the reported pain was new or chronic and, depending on the pain rating, giving non-narcotic medication (i.e., Tylenol) prior, if able. If the pain was severe, then the PRN narcotic could be given. However, RN-A verified staff were to attempt and document non-pharmacological interventions (i.e., ice, repositioning) prior to giving such medication adding they "should be recorded in the progress note." RN-A verified even refused non-pharmacological interventions were expected to be recorded adding, "If you didn't chart it, it didn't happen." During interview on 7/19/23 at 12:12 p.m., the consulting pharmacist (CP) expressed patient specific non-pharmacological interventions should be attempted and recorded in the medical record before PRN medications, including anti-psychotics, were given. This was done so staff know what does and does not work to help the patient and to help reduce the risk of	21535		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 15 unnecessary medication doses. On 7/19/23 at 1:42 p.m., licensed practical nurse unit manager (LPN)-A was interviewed. LPN-A verified they had reviewed R71's medical record and explained R71's completed Pain Tool/Interview (dated 7/3/23) outlined non-pharmacological interventions which could be attempted. LPN-A stated R71 was also on pain monitoring every shift and acknowledged nurses were expected to offer and, if able, provide non-pharmacological interventions prior to giving PRN narcotic medication. LPN-A stated they had not noticed any concerns with such interventions being completed in day-to-day care of R71, however, verified the lack of documentation supporting such adding, "If [staff] didn't chart it, [staff] didn't do it." LPN-A stated it was important to ensure non-pharmacological interventions were attempted to recorded prior to giving PRN narcotic medication to help ensure the resident remains on the medication for as short amount of time as possible. R7's admission Minimum Data Set (MDS), dated 4/19/23, indicated R7 had moderate cognitive impairment and needed extensive assistance with most activities of daily living (ADLs). R7's Physician Orders, dated 4/13/23, indicated R7 had an order for Metoprolol Succinate (an anti-hypertensive medication) Extended Release, 150 milligram (mg) tablet once a day. The order lacked any evidence of parameters on when to hold the medication and lacked any order to monitor blood pressure prior to administration. R7's vital signs indicated R7 had multiple episodes of systolic blood pressure readings of less than 100 millimeters (mm)/mercury(hg) in	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27996	A. BUILDING: _____ B. WING _____	C 07/20/2023

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21535	Continued From page 16 the past 30 days. During observation on 07/18/23 at 8:15 a.m., trained medication assistant (TMA)-A administered R7 his Metoprolol without checking R7's blood pressure and confirmed there were no prompts in the medication administration record (MAR) to check R7's blood pressure prior to medication administration or parameters on when to hold the medication. During an interview on 7/19/23 at 10:10 a.m., licensed practical nurse (LPN)-B stated the expectation was for the nurses and TMAs to monitor blood pressure and pulse prior to administering any anti-hypertensive medication. LPN-B stated she would expect to to see a physician order with parameters on when to hold the medication. LPN-B further stated it would be expected for the nurses to follow up with the physician on a antihypertensive medication that did not have parameters. During an interview on 7/19/23 at 12:12 p.m., the consultant pharmacist (CP) stated she would expect blood pressure to be taken frequently on a resident who had variations in blood pressure, being high or low readings. After reviewing R7's frequent low blood pressure readings and lack of blood pressure monitoring prior to administration of medications, the CP stated monitoring R7's blood pressure prior to administering medications was something she would "definitely make note of and look into." A policy on monitoring blood pressure medication was requested but not received. SUGGESTED METHOD OF CORRECTION: The	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27996	A. BUILDING: _____ B. WING _____	C 07/20/2023

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21535	Continued From page 17 director of nursing, or designee, could review applicable policies on medication management, non-pharmacological intervention documentation, and medication parameters for use; then then inservice appropriate staff and audit to ensure ongoing compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) Days	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/18/2023**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division on 07/18/2023. At the time of this survey, Walker Methodist Westwood II was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Walker Methodist Westwood Ridge II is a 1-story building with a partial basement. The facility was constructed in 2012 and was determined to be of Type V(111) construction. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridors and is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 11 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.