

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 7, 2022

Administrator Walker Methodist Health Center 3737 Bryant Avenue South Minneapolis, MN 55409

RE: CCN: 245055

Cycle Start Date: September 30, 2021

Dear Administrator:

On October 26, 2021, we notified you a remedy was imposed. On December 2, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 23, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 10, 2021 be discontinued as of November 23, 2021. (42 CFR 488.417 (b))

In our letter of October 26, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 30, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

January 7, 2022

Administrator
Walker Methodist Health Center
3737 Bryant Avenue South
Minneapolis, MN 55409

RE: CCN: 245055

Cycle Start Date: September 30, 2021

Dear Administrator:

On December 8, 2021, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of \$650.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on December 2, 2021 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$650.00. In accordance with Minnesota Statutes, \$ 144A.10, subdivision 7, the costs of the reinspection, totaling \$110.20, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$760.20 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health Health Regulation Division, 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

Sincerely,

Kamala Fiske-Downing

Kumalu Fiske Downing

Walker Methodist Health Center January 7, 2022 Page 2

Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 30, 2021

Administrator Walker Methodist Health Center 3737 Bryant Avenue South Minneapolis, MN 55409

RE: CCN: 245055

Cycle Start Date: September 30, 2021

Dear Administrator:

On October 26, 2021, we informed you of imposed enforcement remedies.

On November 16, 2021, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found 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.

The deficiencies not corrected are as follows:

F558 -- S/S: D -- 483.10(e)(3) -- Reasonable Accommodations Needs/preferences F686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer

F761 -- S/S: D -- 483.45(g)(h)(1)(2) -- Label/store Drugs And Biologicals

As a result of the revisit findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 10, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 10, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new

admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of October 26, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 10, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor Marshall District Office

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 30, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/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 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kamala Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 12/02/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
		245055	B. WING			R-C
NAME OF F	PROVIDER OR SUPPLIER	243033	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	11/	16/2021
WALKER	METHODIST HEALT	H CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 00	0}		
{F 000}	was conducted to d CMS Appendix Z En Requirements cited recertification surver facility is now IN con Emergency Prepare INITIAL COMMENT On 11/15/21 through was conducted to for related to a standar 9/30/21. The facility compliance with the 483, Subpart B, Rec Care Facilities.	ey exited on 9/30/21. The impliance with Appendix Z edness Requirements. The edness Requirements and the edness Requirements of the edge o	{F 00	0}		
	H5055306C (MN76 CORRECTED. The following tags v	laint was also reviewed: 946) was found to be were recited: F558, F686, and and NOT be corrected and DMPLIANCE.				
	as your allegation on Department's accept enrolled in ePOC, y	f correction (POC) will serve f compliance upon the stance. Because you are your signature is not required first page of the CMS-2567				
(F)·	onsite revisit of you validate that substa regulations has been					11/00/5
SS=D	CFR(s): 483.10(e)(3	<u> </u>	{F 55			11/23/21
ABORATOR\	CUIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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

Electronically Signed

12/01/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245055	B. WING _			-C 16/2021	
	PROVIDER OR SUPPLIER	TH CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 558}	§483.10(e)(3) The services in the faci accommodation of preferences excependanger the healt other residents. This REQUIREME by: Based on observareview, the facility reach for 1 of 3 residependent upon st. Findings include: R150's annual Min 8/26/21, included, cord injury with fun upper extremities awas totally depend transfers, dressing. R150's Care Area 8/26/21, indicated, due to contractures was at risk for falls balance while sittin loss of arm or leg rindicated R150 had of motion and an indaily living (ADLs). R150's care plan dwas a vulnerable aproviding a safe er	right to reside and receive lity with reasonable resident needs and t when to do so would h or safety of the resident or NT is not met as evidenced tion, interview and document failed to place a call light within sidents (R150) who were aff for assistance. imum Data Set (MDS) dated cognitively intact, had a spinal ctional impairment of both and one lower extremity R150 ent upon staff for bed mobility, and toileting. Assessment (CAA) dated complications with mobility is. The CAA identified R150 and had difficulty maintaining g and during transfers and had movement. The CAA further of functional limitation in range mability to perform activities of without significant assistance. ated 9/10/21, indicated R150 dult. Interventions included evironment for R150. The care	{F 558	Call light placement educati completed on or prior to 11/1 reviewed and determined to and sufficient. Randomized audits, initiated 11/10/21 will remain in effect Focused call light placement performed at least daily for a 14 days, beginning on or bet 11/23/2021. Focused audits resident R150 as well as oth with non-standard call lights previously identified with one concerns related to call lights randomized audits. Results of both randomized audits will be reported to QA and recommendations to material or an angoing compliance. The Administrator or designer responsible for ongoing compliance.	ton or before t. t audits will be a minimum of fore will include her residents and those going s from and Focused API for review aintain		
	due to contractures was at risk for falls balance while sittin loss of arm or leg rindicated R150 had of motion and an ir daily living (ADLs) R150's care plan dwas a vulnerable a providing a safe er plan indicated R15 and was unable to	s. The CAA identified R150 and had difficulty maintaining g and during transfers and had movement. The CAA further d functional limitation in range hability to perform activities of without significant assistance. ated 9/10/21, indicated R150 dult. Interventions included		randomized audits. Results of both randomized audits will be reported to QA and recommendations to ma ongoing compliance. The Administrator or designed	and Focused PI for review aintain ee will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	COI	ATE SURVEY DMPLETED	
		245055	B. WING			R-C / 16/2021	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZI 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{F 558}	needs. The care prisk for falls. Intercall light was with During a continuous 11/15/21, from 11 was observed to be tent-shaped call light one clip, on R150 hand, however, the only on one side, therefore, R150 with light for assistance (RN)-A gavat approximately to boost her up in R150 he would gestated no staff ha R150 stated she call light wasn't punable to see the to contractures ar R150 had a wet, pwould like some wactivate her call light activation but At 1:17 p.m. RN-ADuring an intervier RN-A identified her to R150 when he morning. RN-A stight activation but wrong way causin assistance. Observation on 1 reclined in bed with the second of the sec	olan also indicated R150 was at ventions included ensuring the	{F 5:	58}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245055	B. WING			R-C 16/2021
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	<u> </u>	10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 558}	from R150. R150 w light and requested lunch. Observation and in a.m. with nursing a identified NA-A confacing the wrong wato call for help. During an interview with NA-B who enter R150's call light net the activation buttor would not be able to buring an interview with the assistant distated all residents their reach whenev needed assistance not included in the (POC) call light acceptant staff were not expressed to the staff were not expressed all staff metall light was within when they are in bear call light was not resident. There was	ivation button was facing away ras unable to activate the call an aid so she could order derview on 11/16/21, at 11:49 esistant (NA)-A in R150's room firmed R150's call light was ay and R150 would not be able on 11/16/21, at 11:55 a.m. ered R150's room and stated eded to be turned around with a facing her, otherwise R150 or call for assistance. on 11/16/21, at 12:31 p.m. irector of nursing (ADON) should have call lights within her they were in their room and a The ADON verified R150 was facility plan of correction essibility audits and confirmed educated on how different	{F 55	8}		
		Prevent/Heal Pressure Ulcer 1)(i)(ii)	{F 68	6}		11/23/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245055	B. WING			-C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/2021
\A/A /FF	METHODIOT HEALT	U OENTED		3737 BRYANT AVENUE SOUTH		
WALKER METHODIST HEALTH CENTER			MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 686}	§483.25(b) Skin Into §483.25(b) (1) Press Based on the compresident, the facility (i) A resident receiv professional standar pressure ulcers and ulcers unless the indemonstrates that to (ii) A resident with professional standar professional standar pressure ulcers and ulcers unless the indemonstrates that to (ii) A resident with professional standard	rehensive assessment of a must ensure thates care, consistent with ands of practice, to prevent does not develop pressure dividual's clinical condition hey were unavoidable; and pressure ulcers receives at and services, consistent andards of practice, to revent infection and prevent veloping. In it is not met as evidenced alled to implement identified essure relieving devices and/or sitioning for 2 of 3 residents viewed for pressure ulcers. In imum Data Set (MDS) dated evere cognitive impairment and egia/paresis (weakness or de). R58 required extensive in bed mobility, hygiene and of refuse cares. R58 was at	{F 68	Repositioning and Pressure Prevention education compliprior to 11/10/2021 was revie determined to be current and Randomized audits, initiated 11/10/21 will remain in effect Focused repositioning and prevention audits will be at leweekly for 14 days, beginnin before 11/23/2021. Focused include residents R58 and R as other residents with pressure ulcers. Results of both randomized audits will be reported to QA and monitoring ongoing com The Director of Nursing or discrete prevention and pressure ulcers.	eted on or ewed and d sufficient. I on or before t. Pressure ulcer east twice ag on or audits will sure relieving are at high and Focused Programmer. Esignee will esignee will esignee will	

	IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING) ´co	COMPLETED R-C		
		245055	B. WING		l	/16/2021
	PROVIDER OR SUPPLIER	TH CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 686}	the heels to prever feet. The care plan turn/reposition R58 heel lift boots shou times. The care plabe checked and chefore lunch. The chad a potential for Interventions include for the prevention of encourage small, fit to administer all tree. R58's Kardex (nurs 9/16/21, indicated I bed mobility and shevery 2-3 hours with R58's Order Summ R58 should have heet, every shift, for R58's Provider Proindicated R58 was Prevalon boots, an pillows. R58's Provider Proindicated R58 was Prevalon boots, an pillows, with minime extremities. During an observatiat 1:32 p.m. R58 weed. R58's heels werevalon boots were prevalon boots were provided bed. R58's heels werevalon boots were prevalon boots were plant to the prevention boots were plant to the plant to the prevention boots were plant to the prevention boots were plant to the pla	at pressure on them) on both also indicated to be every two to three hours and ld have been applied at all an indicated R58's brief was to langed after breakfast and care plan further indicated R58 pressure ulcer development. It ded to follow facility protocols of skin breakdown, to requent position changes, and eatments as ordered. See aide worksheet) dated R58 required a total assist for mould have been repositioned in boots applied to R58's feet. The arry dated 1/3/20, indicated and Prevalon boots on both rewound prevention. The arry dated 1/3/20, indicated and Prevalon boots on both rewound prevention. The arry dated 1/3/21, lying in bed, not wearing different heels were not floated on all movement of right the area on a recliner chair across ed the staff would put the	{F 68			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245055	B. WING			I	-C I 6/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT 3737 BRYANT AVENU MINNEAPOLIS, MN	JE SOUTH	1 117	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 686}	R58 was supine in I floated and the Prevacross the room. R150's annual Minit 8/26/21, included, of cord injury with fund upper extremities a was totally dependent transfers, dressing R150's Care Area A 8/26/21, indicated, of due to contractures R150 was at risk formaintaining balance transfers and had let a to the care and had let a to contracture of the care and the care and the care perform activities of significant assistance R150's care plan dawas on scheduled pron-pharmacologic knee contracture, shealing fractures. In repositioning R150. R150 had a history to history of COVID change R150's posespecially if in bed. R150 had a potential decreased physical	ion on 11/16/21, at 11:39 a.m. bed. R58's heels were not valon boots were in a chair mum Data Set (MDS) dated cognitively intact, had a spinal ctional impairment of both and one lower extremity and ent upon staff for bed mobility, and toileting. Assessment (CAA) dated complications with mobility and the capacity of falls and had difficulty entitles and had difficulty entitles and had difficulty entitles and had functional of motion and an inability to fally living (ADLs) without	{F 68	36}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	CO	TE SURVEY MPLETED
		245055	B. WING _			⋜-C / 16/2021
	PROVIDER OR SUPPLIER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 686}	R150's Physician (to turn and repositi bony prominence's During a continuou 11/15/21, from 11: reclined in bed. R1 nurse (RN)-A to be brought R150 her a.m. RN-A told R15 assistant (NA) to he come back to R150 triangle-call light w attached to the she with the activation out of R150's reac side of the call ligh immobility, R150 w and was therefore, activating it to call she often had to ye light doesn't work. to assist R150. During an interview RN-A stated R150 every two hours ar	Orders dated 8/3/19, indicated on R150 every 2 hours off of states. It is observation and interview on 15 a.m. to 1:17 a.m. R150 was 50 stated she asked registered toost her up in bed when RN-A morning medications at 10:00 50 he would get the nursing elp R150, but no one had 0's room since. R150's metal as placed on R150's bed set by one clip instead of two, button facing away from, and h. R150 was able to touch the tracing her, however, due to was unable to see the call light unaware she was not for assistance. R150 stated sell for help because her call At 1:17 p.m. RN-A was located of that he had not been in the gave R150 her	{F 686	,		
	with the assistant of stated staff should devices according care plan. The ADO continuously refuse devices applied, the should have been	or on 11/16/21, at 12:31 p.m. director of nursing (ADON) be applying pressure relieving to the physician orders and/or ON stated if a resident ed to have pressure relieving e interdisciplinary team (IDT) notified and alternative have been considered. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	, ,	TE SURVEY MPLETED	
		245055	B. WING			R-C / 16/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 686}	ADON stated resion necessarily be door care plan would re. The ADON stated their heels floated boots, the staff shore-approach the rehave been provide family regarding the pressure relieving verified that R58 will plan of correction devices audit. The residents should he two hours to avoid development of pressure residents of pressure relieving verified that R58 will plan of correction of devices audit. The residents should he two hours to avoid development of pressure residents and residents and residents and residents are residents.	dent refusals would not cumented but the resident's flect any new interventions. if a resident refused to have as an alternative to Prevalon ould have continued to esident and education should do to the resident and their re risks and benefits of measures. The ADON also was not included in the facility (POC) pressure relieving ADON further stated both ave been repositioned every skin breakdown and the essure ulcers.	{F 68	6}			
	8/1/19, indicated s admitted to the fact pressure ulcers from indicated physician relieving nursing in implemented where was observed. The had been reviewed plan of correction. Label/Store Drugs CFR(s): 483.45(g) \$483.45(g) Labelin Drugs and biological labeled in accordal professional princial appropriate accessional princial propriate accessional princial propriate accessional princial propriate accessional princial princ		{F 7€	:1}		11/23/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	COM	E SURVEY PLETED	
		245055	B. WING			-C 16/2021	
NAME OF	PROVIDER OR SUPPLIER	₹	1	STREET ADDRESS, CITY, STATE, ZIP (10/2021	
14/41 1/21				3737 BRYANT AVENUE SOUTH			
WALKER	R METHODIST HEAL	IH CENTER		MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
{F 761}	§483.45(h) Storage §483.45(h)(1) In a Federal laws, the biologicals in lock temperature contributes a storage of control the Comprehensive Control Act of 197 abuse, except who package drug distinguantity stored is be readily detected. This REQUIREMED by: Based on observative review, the facility discontinued narcof in a timely man storage rooms ob Findings include: During an observative at 3:08 p.m. a bot narcotic) that was 1/7/20, was found refrigerator. Regist Lorazepam was lated and should have the R90's previous phindicated R90 had Lorazepam solutions.	ge of Drugs and Biologicals accordance with State and facility must store all drugs and ed compartments under proper rols, and permit only authorized access to the keys. It facility must provide separately affixed compartments for led drugs listed in Schedule II of the Drug Abuse Prevention and and other drugs subject to en the facility uses single unit tribution systems in which the minimal and a missing dose cand. ENT is not met as evidenced ation, interview, and record failed to ensure expired and/or otic medications were disposed ner from 1 of 4 medication served for medication storage. Ation and interview on 11/16/21, the of liquid lorazepam (a filled by the pharmacy on in the sixth-floor medication stered nurse (RN)-B verified the last used by R90 over a year ago	{F 76	A comprehensive review of carts, medication rooms are refrigerators will be completed before 11/23/2021 and all refrigerations, or improperly dated medications were refered be destroyed according to a said and the performed across all units of basis. Audits will be review Director of Nursing or designations. Results of the audits will be QAPI for review and further recommendations. The Director of Nursing or be responsible for ongoing.	and medication atted on or medications not expired stored and moved and will facility policy. will be on a weekly ed by the gnee. e reported to r designee will		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245055	B. WING			R-C / 16/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		710/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CX (EACH CORRECTIVE ACTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 761}	R90's Medication A indicated R90 had solution after 1/14/ During an interview with the assistant of stated narcotic mediscontinued over a destroyed to avoid confusion. The AD medication room rethe facility plan of ostorage audit. The facility Medica 12/7/16, indicated be immediately rerof according to policy.	Administration Record (MAR) not received Lorazepam 20. v on 11/16/21, at 12:35 p.m. director of nursing (ADON) dications that had been a year ago should have been the risk of diversion and ON verified the sixth-floor efrigerator was not included in correction (POC) medication tion Storage policy dated outdated medications were to moved from stock and disposed icy. There was no indication in reviewed and/or revised per	{F 76	51}		



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered

Decemember 8, 2021

Administrator Walker Methodist Health Center 3737 Bryant Avenue South Minneapolis, MN 55409

Re: CCN: 245055

Cycle Start Date: September 30, 2021

Dear Administrator:

On November 16, 2021, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 30, 2021 with orders received by you electronically on .

State licensing orders issued pursuant to the last survey completed on September 30, 2021, found not corrected at the time of this November 16, 2021 revisit and subject to penalty assessment are as follows:

905	Rehab Positioning MN Rule 4658.0525 Subp. 4	\$350.00
1610	Medicine Cabinet and Preparation Area; storage MN Rule 4658.1340 Subp. 1	\$300.00

The details of the violations noted at the time of this revisit completed on November 16, 2021 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of \$650.00 per day beginning on the day you receive this notice.

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

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Walker Methodist Health Center Decemember 8, 2021 Page 2

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

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

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

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Program Assurance Supervisor Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit

Walker Methodist Health Center Decemember 8, 2021 Page 2

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File Kami Fiske-Downing, Licensing and Certification Program

Penalty Assessment Deposit Staff

Walker Methodist Health Center Decemember 8, 2021 Page 2



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

October 26, 2021

Administrator Walker Methodist Health Center 3737 Bryant Avenue South Minneapolis, MN 55409

RE: CCN: 245055

Cycle Start Date: September 30, 2021

Dear Administrator:

On September 30, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On September 29, 2021, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 10, 2021.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 10, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 10, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 30, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor St. Cloud A District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: karen.aldinger@state.mn.us

Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 30, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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 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:

> William Abderhalden, Fire Safety Supervisor **Deputy State Fire Marshal** Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 11/12/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
	245055		B. WING			C / 30/2021
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP C 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		75072021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY		SHOULD BE	(X5) COMPLETION DATE
	with Appendix Z, E Requirements, §48 during a standard r facility was NOT in The facility's plan of as your allegation of Department's acceenrolled in ePOC, at the bottom of the form. EP Training Prograt CFR(s): 483.73(d)(1), §48 §441.184(d)(1), §48 §483.73(d)(1), §48 §485.68(d)(1), §48 §485.920(d)(1), §48 [For RNCHIs at §4 Hospitals at §482.2 at §484.102, "Orgat §486.360 (1) Training prograthe following: (i) Initial training in policies and proceed and proceed staff, individuals prarrangement, and expected roles. (ii) Provide emergeleast every 2 years (iii) Maintain documpreparedness train	of correction (POC) will serve of compliance upon the eptance. Because you are your signature is not required the first page of the CMS-2567 am (1) 16.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)(1), 86.360(d)(1), §491.12(d)(1). 403.748, ASCs at §416.54, 15, ICF/IIDs at §483.475, HHAs inizations" under §485.727, RHC/FQHCs at §491.12:] am. The [facility] must do all of emergency preparedness dures to all new and existing roviding services under volunteers, consistent with their ency preparedness training at 5. mentation of all emergency	ΕO			11/10/21

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

(X6) DATE

Electronically Signed

11/05/2021

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.

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(.	(X3) DATE SURVEY COMPLETED		
	245055		B. WING			C 09/30/2021		
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZI 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	P CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
E 037	procedures. (v) If the emergency procedures are sigmust conduct train procedures. *[For Hospices at § hospice must do al (i) Initial training in policies and procedures expected roles. (ii) Demonstrate structures (iii) Provide emergency prepare employees (includi special emphasis procedures necess others. (v) Maintain docum preparedness train (vi) If the emergency prepare procedures are sigmust conduct train procedures. *[For PRTFs at §44 program. The PRT (i) Initial training in policies and procedures are sigmust conduct train procedures and procedures are sigmust conduct train procedures.	ey preparedness policies and nificantly updated, the [facility] ing on the updated policies and [6418.113(d):] (1) Training. The I of the following: emergency preparedness dures to all new and existing and individuals providing angement, consistent with their eaff knowledge of emergency ency preparedness training at riew and rehearse its edness plan with hospice ng nonemployee staff), with placed on carrying out the eary to protect patients and mentation of all emergency	EO	37				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
	245055		B. WING			C 09/30/2021	
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP C 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TION SHOULD BE COMPLÉTIC THE APPROPRIATE DATE		
E 037	preparedness train (iii) Demonstrate st procedures. (iv) Maintain documpreparedness train (v) If the emergency procedures are sig must conduct train procedures. *[For PACE at §460 organization must of (i) Initial training in policies and procedures are sig must conduct train procedures. (ii) Provide emerge least every 2 years (iii) Demonstrate st procedures, include what to do, where to case of an emerge (iv) Maintain docum (v) If the emergency procedures are sig must conduct train procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in policies and procedures staff, individuals pr arrangement, and expected role.	ing every 2 years. caff knowledge of emergency mentation of all emergency ing. cy preparedness policies and nificantly updated, the PRTF ing on the updated policies and 0.84(d):] (1) The PACE do all of the following: emergency preparedness dures to all new and existing oviding on-site services under ractors, participants, and ent with their expected roles. ency preparedness training at . caff knowledge of emergency ing informing participants of to go, and whom to contact in	EO	37			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	(X3) DATE SURVEY COMPLETED	
245055		245055	B. WING		C 09/30/2021		
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZII 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED T		(X5) COMPLETION DATE	
E 037	preparedness trair (iv) Demonstrate is procedures. *[For CORFs at § CORF must do all (i) Provide initial tripreparedness poliand existing staff, under arrangement with their expecter (ii) Provide emergleast every 2 years (iii) Maintain docur (iv) Demonstrate is procedures. All neand assigned spethe CORF's emerging their first workday include instruction alarm systems an equipment. (v) If the emerge procedures are significated in training in procedures. *[For CAHs at § 48] The CAH must do (i) Initial training in policies and procedures and where necessing personnel, and guicooperation with first procedures.	mentation of all emergency ning. staff knowledge of emergency 485.68(d):](1) Training. The of the following: aining in emergency cies and procedures to all new individuals providing services at, and volunteers, consistent d roles. ency preparedness training at	EC	037			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245055	B. WING		09/30/2021		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C		30/2021	
WALKER METHODIST HEALTH CENTER				3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 037	and volunteers, corroles. (ii) Provide emerge least every 2 years. (iii) Maintain docum (iv) Demonstrate st procedures. (v) If the emergen procedures are sign must conduct traini procedures. *[For CMHCs at §4 CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of the demonstrate staff k procedures. There emergency prepared years. This REQUIREMED by: Based on interview facility failed to prov preparedness training based on the facility plan (EP) for 3 of 3 and NA-P) reviewer affect all 217 reside volunteers and visit Findings include: On 09/30/21, at 4:1	g services under arrangement, insistent with their expected incy preparedness training at a mentation of the training. It is inentation of the training and inficantly updated, the CAH ing on the updated policies and inficantly updated, the CAH ing on the updated policies and inficantly updated, the CAH ing on the updated policies and inficantly updated, the CAH ing on the updated policies and inficantly updated, the CAH ing on the updated policies and inficantly updated, the CAH ing on the updated policies and inficantly updated, the consistent roles, and procedures to all new individuals providing services and volunteers, consistent roles, and maintain intertaining. The CMHC must provide edness training at least every 2 ing at least annually which was a yemergency preparedness staff members (RN-D, RN-S ing at least annually which was a yemergency preparedness staff members (RN-D, RN-S ing at least annually which was a yemergency preparedness staff members (RN-D, RN-S ing at the facility.	EO	An audit was conducted for related to both initial emerge preparedness training and a Any active staff found to be compliance will complete ne emergency preparedness tr before 11/10/2021 or they w from the schedule until train complete. Audits will be conducted mo	ency innual training. out of ecessary aining on or ill be removed ing is		
	reviewed with the a			minimum of 6 months to mo			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245055	B. WING	B. WING			30/2021
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	30/2021
\A/A /FF	METHODIOTHEALT	U OFNITED		37	37 BRYANT AVENUE SOUTH		
WALKER	R METHODIST HEALT	H CENTER		M	INNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From pa administrator indica evidence of EP train calendar year of 20 administrator indica during 2020 resulte not available to ther employee transcript nurse (RN)-D had E on 12/16/19 and nu 12/20/19. The facilities Emerg dated 1/1/20, identifitraining to staff upo INITIAL COMMENT On 9/27/21 - 9/30/2 survey was conductinvestigation was all was found to be NO requirements of 42 Requirements for L	ge 5 Ited the facility did not have hing for the staff for entire 20, nor in 2021. The ited training personnel change d in EP training information as m. The administrator provided its which showed registered EP training last 1/31/19, RN-S raing assistant (NA)-P on gency Preparedness Plan fied they would provide in hire and annually. The seconducted is a standard recertification and the seconducted in the compliance with the CFR 483, Subpart B, ong Term Care Facilities. Islaints were found to be ED: 217) (MN58155), 507), 293), 946), 631), 812), 624), 624),	E 0			e tion oe	DATE
	H5055295C (MN57 H5055304C (MN59 H5055297C (MN64 H5055297C (MN64 H5055301C (MN67	811), 144), 286),					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	COMPLETED		
	245055		B. WING_		C 09/30/2021		
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 000	The following comp	ge 6 laint was SUBSTANTIATED d at F580: H5055306C	F 00	00			
	The facility's plan or as your allegation or Departments acceptenrolled in ePOC, yat the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are four signature is not required of first page of the CMS-2567 of submission of the POC will cion of compliance.					
	onsite revisit of you	ercise of Rights	F 55	50		11/10/21	
	self-determination, access to persons	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
	with respect and dig resident in a manne promotes maintena her quality of life, re	ility must treat each resident gnity and care for each er and in an environment that nce or enhancement of his or ecognizing each resident's cility must protect and of the resident.					
	access to quality ca	facility must provide equal are regardless of diagnosis, n, or payment source. A facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C			
		245055	B. WING _		09/30/2021		
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 550	must establish and practices regarding provision of service residents regardles §483.10(b) Exercise The resident has the rights as a resident or resident of the U §483.10(b)(1) The resident can exercinterference, coercifrom the facility. §483.10(b)(2) The free of interference reprisal from the facility. §483.10(b)(2) The free of interference reprisal from the facility. This REQUIREME by: Based on observative review, the facility treatment for 2 of a reviewed, who had staff treatment. Findings include: R59's quarterly Min 7/21/21, included, of heart failure and from staff for ambut the facility of the staff for ambut the facility of the staff for ambut the facility of the staff for ambut the	I maintain identical policies and g transfer, discharge, and the es under the State plan for all as of payment source. See of Rights. The right to exercise his or her to f the facility and as a citizen	F 55	R59 & R47 received the care a services to ensure privacy and Their care plans have been revupdated as needed. Policies and procedures were rand remain appropriate Nursing staff will be educated or resident privacy, knocking on drawaiting response before entering greeting and engaging with resiminary when providing assistance and	dignity. iewed and eviewed n ensuring oors and ng, dents		
		risible," when staff were in her the staff enter the room without		Audits for monitoring protection resident dignity and privacy will			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
245055 B. WING	C - 09/30/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT	
WALKER METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOU	тн
MINNEAPOLIS, MN 5540	9
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED	OF CORRECTION (X5) ACTION SHOULD BE TO THE APPROPRIATE IENCY) (X5) COMPLETION DATE
knocking and say, "are you done?" R59 stated as soon as the staff are finished, they quickly leave the room without asking if she needed anything else. During an observation on 9/27/21, at 1:25 p.m. nursing assistant (NA)-G knocked on the door, R59 yelled out, "not now." NA-G walked into the room and again R59 stated, "please come back later." NA-G walked past R59, removed the trash bag, and walked out the door, not acknowledging her. At 1:37 p.m. R59 turned on her call light to let NA-G know she was ready to use the bathroom and then lay down. At 1:44 p.m. NA-G knocked on R59's door and entered the room before R59's could grant her permission. NA-G only said, "Your call light is on," as she turned the call light off. R59 told NA-G, "I want to go to bed." NA-G did not respond to her request, but turned around and walked out of the room. At 1:52 p.m. NA-G walked back into R59's room and assisted R59 to the toilet. NA-G then walked back into the room and asked R59, "done yet?" R59 stated, "no." NA-G stayed in the room without speaking to R59, singing in a foreign language until R59 indicated she was finished. NA-G then assisted R59 to her bed and left the room without making any conversation, or asking R59 if she was comfortable or if she needed anything else. When interviewed on 9/30/21, at 3:15 p.m. registered nurse (RN)-K stated her expectation for all staff when entering a resident's room was to greet the resident, ask what they needed, and	ff have also been ng resident s nformation and on administration. ance will be ensured kly observational of 8 weeks. ttee will review audit ther

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE S		
		245055	B. WING			0/2021
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 550	director of nursing ensure all the residence they leave the root dignity training who facility. R47's quarterly MI cognitively intact we received insulin injextensive staff asstransfers. R47's care plan day a vulnerable adult depressive disorded bi-polar with a presenter ventions included.	on 9/30/21, at 4:57 p.m. the (DON) stated all staff are to dent's needs are met before m. DON stated all staff receive en they start working at the DS dated 7/13/21, included, with a diagnosis of diabetes and sections daily. R47 required sistance with dressing and ated 7/14/21, indicated R47 was with a history of major er related to anxiety and ference to isolation. ded allowing R47 to express ding a safe environment for	F 55	0		
	R47. R47's Order Sumr indicated blood gluther report also incapart solution on meals, and four urpen-injector, three During observation stood next to R47, and asked him louthere were 6 otherstated, "no." RN-N to check his blood RN-N wheeled R4 and faced him tow other residents and single states and	mary Report dated 9/30/21, ucose monitoring before meals. dicated R47 received insulin a sliding scale by injection, with hits of NovoLog (insulin) by				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	245055		B. WING _			C 30/2021
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	1 03/	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 550	expose his abdome entire dining room, interviewed, RN-N sthe dining room, "it When interviewed of stated he did not liking the hallway where by. R47 stated he wadministered in his was embarrassing. When interviewed of DON stated staff showhen administering stated the medication not a private setting walk by and see the The facility Quality of 8/1/19, indicated redignity and respect enhancing residents indicated staff were which protected resinformation including outside the hearing the public. The policipromote and protected resinformation and protected resinformation including the public. The policipromote and protected residents and protected residents and protected residents.	ge 10 en, still within eyesight of the and injected the insulin. When stated they give medications in is how it's always done." en 9/30/21, at 5:56 p.m. R47 e receiving his insulin injection e other people were walking yould have preferred to have it room where it was private. It en 9/30/21, at 1:54 p.m. the hould provide residents privacy injections. The DON further on cart by the dining room was a because other people could enjection being administered. The Life-Dignity policy, revised sidents were to be treated with at all times by maintaining and is self-esteem. The policy to maintain an environment sident's confidential, clinical and conducting conversations range of other residents and cy also indicated staff should a resident privacy, including and assistance with cares and	F 55	50		
	treatments.	modations Needs/Preferences	F 55	58		11/10/21
	services in the facil accommodation of					

245055 B. WING	C 09/30/2021
	00/00/2021
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558 Continued From page 11 endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to place a call light within reach for 1 of 3 residents (R150) reviewed who were dependent upon staff for assistance and were able to use a call light for assistance. Findings include: Findings include: Findings include: R150's annual Minimum Data Set (MDS) dated 8/26/21, included, cognitively intact, had a spinal cord injury with functional impairment of both upper extremities and one lower extremity and was totally dependent upon staff for bed mobility, transfers, dressing and toileting. R150's Care Area Assessment (CAA) dated 8/26/21, indicated, complications with mobility due to contractures. The CAA also indicated R150 was at risk for falls and had difficulty maintaining balance while sitting and during transfers and had loss of arm or leg movement. The CAA further indicated R150 had functional limitation in range of motion and an inability to perform activities of daily living (ADLs) without significant assistance. R150's care plan reviewed and revise as needed. R150's care plan also were reviewed and remain appropriate. Nursing staff will be educated to ensure call lights are within resident reach at at times. Monitoring to ensure compliance will be ensured through random daily audits of call light placement for 14 days, then weekly for a minimum of 6 weeks. Facility QAPI Committee will review auditions and make further recommendations. Director of Nursing or designee will be responsible for ensuring compliance R150's care plan also day indicated R150 are a camunication deficit and was unable to press the call light well. Interventions included staff anticipating R150's needs. The care plan also indicated R150 was at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	245055		B. WING			30/2021
	NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	1	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 558	at 6:03 p.m. R150 or and no covers. R15 needed a boost in Illimited movement if able to move her right metal, triangle call sheet within her real hanging off the right was unable to active. During an observat R150's call light was unable to active a.m. registered nur R150's call light. During an observat R150 activated the a.m. nursing assist room to assist R150 boosted in bed. NA NA-M. NA-N and Nattached the call light activation button far and NA-M left R150 activate her call but The facility Call Light indicated all staff m call light was within when they are in be	ion and interview on 9/27/21, was in bed wearing only a brief 50 stated she was cold and bed. R150 was contracted with all extremities. R150 was ght hand slightly to activate her light if it was attached to the ach; however, the call light was at side of the bed and R150 ate it or see it. ion on 9/28/21, at 11:01 a.m. as turned around with the cing away from R150. R150 ate her call button. At 11:05 se (RN)-P was notified about ion on 9/29/21, at 7:34 a.m. call light on her bed. At 7:35 ant (NA)-N entered R150's 0. R150 requested to be -N left briefly and returned with A-M boosted R150 in bed then that to the bed with the cing away from R150. NA-N 0's room. R150 was unable to	F 55	8		
F 580 SS=D	resident. Notify of Changes (CFR(s): 483.10(g)((Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	F 58	0		11/10/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245055	B. WING _		09	C / 30/2021	
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP O 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
§4 (i) cocce (A reph (B m details click) a trecocce (A reph (B m details) (C) a treco	A facility must in insult with the resunsistent with his presentative(s) who had a coldent investigation in tervential of a significant change in results in injury and a significant change in the coldent in the colde	diffication of Changes. Immediately inform the resident; Isident's physician; and notify, or her authority, the resident Inher there is- olving the resident which It has the potential for requiring ion; ange in the resident's physical, ocial status (that is, a Inth, mental, or psychosocial threatening conditions or ins); treatment significantly (that is, ue an existing form of diverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the sident representative, if any, om or roommate assignment 3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on. st record and periodically is (mailing and email) and	F 58	0			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245055	B. WING		C 09/30/2021		
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	1 00/0	0/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE	
F 580	§483.10(g)(15) Admission to a conthat is a composite §483.5) must discledits physical configul locations that compart, and must speroom changes between the second control of th	nposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various prise the composite distinct cify the policies that apply to ween its different locations	F 580	R197 had discharged prior to time survey Policy and procedure for change of condition notification reviewed and remains appropriate. Licensed staff have been educate identification of change of condition proper notification of family and privity proper documentation. Monitoring to ensure compliance we ensured through random weekly caudits of residents experiencing a of condition to ensure proper notificand documentation has occurred. will be conducted for a minimum of weeks. Facility QAPI Committee will review results and make further recommendations. The Director of Nursing or designed be responsible for maintaining one compliance.	of d on on, rovider will be chart change ication Audits of 8 w audit		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245055	B. WING		C 09/30/2021		
	NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHOOTH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580	Staff were directed medications as ord monitor R197's vita the physician of signal R197's progress not p.m. indicated R19 not specific except R197's PN dated 9 R197 was readmitt hospitalization for control of the second read to get out R197's occupations 9/11/21, at 4:03 p.m. see R197 and R19 fatigued to participal R197's physical the at 11:54 p.m. indicated too fatigued, had maddominal pain. R197's OT PN date indicated OT reatter evaluation with phy further indicated R197's order to see the second read of the second read to see the second read to see the second read to second read the	to administer R197's lered. Further, staff were to al signs, as ordered, and notify inficant abnormalities. ote (PN) dated 9/10/21, at 3:10 7 was not feeling well and was for a poor appetite. //11/21, at 7:38 a.m. indicated ed to the facility after diverticulitis and pneumonia. dated 9/11/21, at 10:33 a.m. used therapy because she was of bed. all therapy (OT) PN dated m. indicated OT attempted to 7 declined stated she was too ate. erapy (PT) PN dated 9/13/21, ated R197 reported she was ausea and vomiting, and 197's PT PN further indicated d. ed 9/13/21, at 3:27 p.m. empted to see R197 for an exical therapy (PT) present. PN 197 was confused and stated gwell, was stating she'll try	F 5	80			
	R197 had recently Flagyl for pneumor	itioner (NP) PN dated 9/13/21, finished levofloxacin and nia and diverticulitis. R197 had unds using supplemental					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245055	B. WING			C 9/30/2021	
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		5/56/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580	oxygen with noted further indicated R pain and tendernes and lower right mid cough and congest plan to recheck a band complete blood There was no evide was contacted. R197's PN dated 9 complained of stom medications. R197 There was no indic representative was R197's PN dated 9 therapy reported retherapy attempted further indicated to know confusion. PN R197 talking out lor room (hallucination talking to FM-A and PN further indicated did not know were dressed in flowing bites, complained or pain, and had a conpressure was 100/4 voice message won no indication R197' notified or if the NP R197's PN dated 9 R197 was alert and and ate bites of breindicated they would indicated they would further indicated they would not for indicated t	expiratory wheezes. PN 197 skin was pale in color, is was reported in left quadrant quadrant. PN indicated with a ion. PN further indicated a lasic metabolic panel (BMP) d count (CBC) on 9/16/21. ence R197's representative /14/21 at 2:18 p.m. R197 hach pain and required pain ate 20% of her breakfast. ation the provider or resident	F 5	80			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED C
		245055	B. WING _		09	/30/2021
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	notified or if the NIR R197's PN dated 9 R197 was found to arm measuring on PN further indicate left for NP-A. R197's PN dated 9 R197 refused ther nursing reported to get out of bed. R197's PN dated 9 FM-A was notified 12:30 p.m. on R19 R197 experienced and required assis indicated, FM-A dhospital and FM-A R197's PN dated 9 PN indicated FM-A resident be seen in and sleepiness. Pa 2:00 p.m. The NP R197's Lab Result indicated an eleval may indicate infection potassium level, we elevated calcium level the diagnosis of faclostridium difficile infection (UTI). R197's Hospital D 9/24/21, indicated the diagnosis of faclostridium difficile infection (UTI). R197's Hospital D 9/24/21, indicated the diagnosis of faclostridium difficile infection (UTI).	P had actually been notified. 2/16/21, at 3:08 p.m. indicated to have a skin tear on her left to centimeter (cm) by 0.5 cm. and a voice message would be 2/16/21, at 3:35 p.m. indicated apy. PN further indicated to therapy she had refused to 2/17/21, at 2:02 p.m. indicated by social worker (SW) around 2/1's updated change in status of lethargy, at less at meals, stance with eating. PN further emanded R197 be sent to the	F 58			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245055	B. WING	B. WING		C 09/30/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	30,2021
WALKER	R METHODIST HEALT	H CENTER			737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	from a skilled nursi weakness and lethal During an interview PT-A stated when so room prior to her hashe was too tired a with taking sips of very PT-A stated they has been been been been been been been bee	ng facility with increase in argy. on 9/30/21, at 12:19 p.m. she went to see R197 in her ospitalization, and R197 stated and required PT-A to assist her water because she was weak. ad notified the nursing staff. on 9/30/21, at 12:35 p.m. otified FM-A on 9/17/21, of the concern with R197 not aware nursing had not kept	F 5	880			
	During an interview	on 9/30/21, at 1:30 p.m. NP- aff left a voice message on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		I DENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245055	B. WING _			C / 30/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	R197's skin tear or notifications regard vomiting, confusion stated she saw R1 911 due to her constated her expecta provider with any condition as soon. During an interview family member (FN after she received the SW stating R1 lethargic. FM-A state facility from the and diverticulitis. F contacted 911 becomment and her potassium infection. FM-A stated she returned to the social worker called During an interview OT-A stated she at times for an OT extends to participate they had notified in the facility's policy dated 5/23/12, indinot able to understating impaired cognition representative will	in her arm, but no other ding R197 who had nausea, in, and hallucinations. NP-A 97 just after the FM-A called cerns in R197 health. NP-A tion for staff would call the concerns with a change of as possible. If you on 9/30/21, at 2:01 p.m. If you had the contacted 911 a phone call on 9/17/21, from 97 had trouble eating and was ated R197 had just returned to a hospital due to pneumonia M-A further stated she ause of the concerns with her ind lethargic. FM-A stated R197 had le	F 58				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ID PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		, COV	E SURVEY IPLETED		
		245055	B. WING_			C 30/2021
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	rehabilitation. The fiphysicians of a chapolicy. Staff were diparties of any signific condition as soon a seriousness of connotification in reside directed stat to not symptoms, and labacute illness needing would be reported I Treatment/Svcs to CFR(s): 483.25(b)(Standard of the compresident, the facility (i) A resident receive professional standard pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with president w	racility's directed staff to notify nge in condition per facility irected to notify responsible ficant and/or acute change in as possible and as indicated by dition, and further document ent's chart. The facility's policy fy physician of specific signs, oratory values suggestive of ng immediate assessment by licensed staff. Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. orehensive assessment of a must ensure thates care, consistent with ards of practice, to prevent does not develop pressure idividual's clinical condition they were unavoidable; and oressure ulcers receives	F 58	30		11/10/21
	with professional st promote healing, promote healing, promote healing, professional states and the states are states and the states are states and the states are states are states and the states are states ar	nt and services, consistent candards of practice, to revent infection and prevent veloping. NT is not met as evidenced or, observation, and document ailed to implement pressure minimize the risk for the essure injuries for 1 of 3 riewed for pressure injuries.		R58 cares were provided by stacare plan on 9/29/21 as 1:06pm Surveyor observations and inter Resident's care plan has been rand updated as needed. Policy and Procedures reviewed revised as needed.	per State views. eviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245055	B. WING			09/3	30/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	JO/2021
14/41 1/55	METHODIOT HEALT	II OENTED		37	737 BRYANT AVENUE SOUTH		
WALKER	R METHODIST HEALT	H CENTER		M	IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	R58's quarterly Min 7/27/21, included swith diagnoses included stoke with hemiple paralysis on one sit staff assistance with dressing and did not risk for pressure uldersk for p	imum Data Set (MDS) dated evere cognitive impairment uding, diabetes, dementia and egia/paresis (weakness or de). R58 required extensive in bed mobility, hygiene and of refuse cares. R58 was at zers. ded 7/28/21, indicated R58 had refuse cares. R58 into his eakfast and back into bed are plan indicated R58 was to so (special boots that off-load at pressure on them) on both also indicated to every two to three hours and do have been applied at all in indicated R58's brief was to anged after breakfast and are plan further indicated R58 pressure ulcer development. The ded to follow facility protocols of skin breakdown, to equent position changes, and atments as ordered. Description of the detection of the detecti	F 6	86	Care Plans of residents that require assistance with turning and reposit and the need for incontinence care been reviewed and revised to ensuraccuracy. Nursing staff will be educated on for skin interventions per Kardex and Orlan. Monitoring to ensure compliance we ensured through random weekly at resident repositioning per care pland placement of adaptive interventions. Audits will continue for a minimum weeks. The facility QAPI committee will revaudit results and make further recommendations. Director of Nursing or designee will responsible for ensuring compliance.	ioning have re illowing Care ill be udits of and s. or 8	
		gress Note dated 7/15/21, lving in bed, not wearing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED C		
	245055	B. WING _		09	/30/2021	
		STREET ADDRESS, CITY, STATE, ZIP CO 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		<u> </u>		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE	
Prevalon boots, ar pillows. R58's Provider Provider R58 was Prevalon boots, ar pillows, with minimextremeties. During an interview on 9/29/21 from 90 supine in bed at a television on and thave Prevalon boopressure injury prevalon books are injuries pressure injury prevalon books and the state of the prevalum of the	ogress Note dated 9/13/21, solying in bed, not wearing and heels were not floated on the last was and continuous observation 34 a.m. to 10:10 a.m. R58 was 30-degree angle with the last he blinds closed. R58 did not lots (a soft boot worn to prevent on his feet as ordered for evention. R58 stated staff had rief or repositioned him since he known time that morning. At the last red nurse (RN)-O entered continue the tube feeding. For without repositioning R58. We and continuous observation 0:37 a.m. to 12:45 p.m. R58 at a 30-degree angle without lon boots on his feet. R58 at a 30-degree angle without lon boots	F 68	6			
	PROVIDER OR SUPPLIER R METHODIST HEAL SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From p Prevalon boots, ar pillows. R58's Provider Pro indicated R58 was Prevalon boots, ar pillows, with minimextremeties. During an interview on 9/29/21 from 9: supine in bed at a television on and thave Prevalon bood pressure injuries) pressure injury pre not changed his bivoke up at an unk 10:10 a.m. registe R58's room to disc RN-O left R58's roo During an interview on 9/29/21, from 1 was supine in bed the ordered Preva stated staff had sti brief or reposition unknown time. At (NA)-L entered R5 R58's closet, then lunch. NA-L did no R58. At 12:00 p.m. 12:01 p.m. NA-M of stated R58 often in and placed it on R NA-M did not repo apply the Prevalor	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 Prevalon boots, and heels were not floated on pillows. R58's Provider Progress Note dated 9/13/21, indicated R58 was lying in bed, not wearing Prevalon boots, and heels were not floated on pillows, with minimal movement of right	PROVIDER OR SUPPLIER R METHODIST HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 Prevalon boots, and heels were not floated on pillows. R58's Provider Progress Note dated 9/13/21, indicated R58 was lying in bed, not wearing Prevalon boots, and heels were not floated on pillows, with minimal movement of right extremeties. During an interview and continuous observation on 9/29/21 from 9:34 a.m. to 10:10 a.m. R58 was supine in bed at a 30-degree angle with the television on and the blinds closed. R58 did not have Prevalon boots (a soft boot worn to prevent pressure injury prevention. R58 stated staff had not changed his brief or repositioned him since he woke up at an unknown time that morning. At 10:10 a.m. registered nurse (RN)-O entered R58's room to discontinue the tube feeding. RN-O left R58's room without repositioning R58. During an interview and continuous observation on 9/29/21, from 10:37 a.m. to 12:45 p.m. R58 was supine in bed at a 30-degree angle without the ordered Prevalon boots on his feet. R58 stated staff had still not been in to change his brief or reposition him since he woke up at an unknown time. At 11:00 a.m. nursing assistant (NA)-L entered R58's room, put a bag of briefs in R58's closet, then left, stating she was going to lunch. NA-L did not provide care or reposition R58. At 12:00 p.m. R58 activated his call light. At 12:01 p.m. NA-M entered R58's room. NA-M stated R58 often misplaced his television remote and placed it on R58's lap and left the room. NA-M did not reposition or change R58's brief or apply the Prevalon boots to R58's feet. At 12:09	PROVIDER OR SUPPLIER 245055 R METHODIST HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 Prevalon boots, and heels were not floated on pillows. With minimal movement of right extremeties. During an interview and continuous observation on 9/29/21 from 9:34 a.m. to 10:10 a.m. R58 was supine in bed at a 30-degree angle with the television on and the blinds closed. R58 did not have Prevalon boots (a soft boot worn to prevent pressure injury prevention. R58 stated staff had not changed his brief or repositioned him since he woke up at an unknown time that morning. At 10:10 a.m. registered nurse (RN)-O entered R58's room without repositioning R58. During an interview and continuous observation on 9/29/21, from 10:37 a.m. to 12:45 p.m. R58 Board of the prevention of discontinuous observation on 9/29/21, from 10:37 a.m. to 12:45 p.m. R58 During an interview and continuous observation on 9/29/21, from 10:37 a.m. to 12:45 p.m. R58 Board of the prevention of discontinue the tube feeding, RN-O left R58's room without repositioning R58. During an interview and continuous observation on 9/29/21, from 10:37 a.m. to 12:45 p.m. R58 was supine in bed at a 30-degree angle without the ordered Prevalon boots on his feet. R58 stated staff had still not been in to change his brief or reposition him since he woke up at an unknown time. At 11:00 a.m. nursing assistant (NA)-L entered R58's room, put a bag of briefs in R58's closet, then left, stating she was going to lunch. NA-L did not provide care or reposition R58's toles of the misplaced his television remote and placed it on R58's lap and left the room. NA-M did not reposition or change R58's brief or apply the Prevalon boots to R58's feet. At 12:09	RECORRECTION DENTIFICATION NUMBER: 245055 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 MINNEAPOLIS, MN 55409	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245055	B. WING		09	C / 30/2021	
	PROVIDER OR SUPPLIER	'H CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			33/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	feeding tube then lebed at a 30-degree his feet. At 12:15 p room and applied eleft without repositis supine, in bed at a pressure relieving lep.m. During an interview NA-L stated reside their briefs checked she had not repositisince around 8:00 as he would go back NA-L further stated contracted if he was frequently. NA-L stated reside and their briefs checked she had not reposition as he would go back NA-L further stated contracted if he was frequently. NA-L stated reside and their briefs checked and their briefs c	eft. R58 remained supine in angle with no boots applied to m. RN-O returned to R58's eye drops to R58's eyes then oning R58. R58 was observed 30-degree angle with no boots on his feet until 12:45 on 9/29/21, at 12:46 p.m. Into should be repositioned and devery two hours. NA-L stated tioned or checked R58's brief a.m. or 8:30 a.m. NA-L stated to assist R58 after lunch. R58 could get "bed sores" or sont repositioned or changed ated she did not know what the degarding the Prevalon preferred to wear them at the dregarding the prevalon preferred to wear them at the dregarding the prevalon of the prevaluation and interview on 9/29/21, and NA-L entered R58's room and change R58's brief. RN-O med R58 in bed. NA-L took the of R58's closet and applied R58 had a blanchable, opproximately three centimeters eft heel. RN-O stated she had not on R58's heel previously.	F 6	86			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245055	B. WING _			C / 30/2021
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	Prevalon boots wer blanket. During an interview director of nursing (follow each residen schedule. The DON order for Prevalon It the boots should hat The DON also state documented a resident or be repositioned, Interdisciplinary Teaevaluation of the restated if Prevalon be resident was not reresident could have the facility Skin and 8/1/19, indicated standmitted to the facility pressure ulcers from indicated physician relieving nursing intimplemented when was observed. Bowel/Bladder Inco CFR(s): 483.25(e)(1) The facility skin and shaded in the facility skin and shad	on 9/30/21, at 1:54 p.m. the (DON) stated staff should it's changing and repositioning stated if a resident had an coots to be applied every shift, ave been on the resident's feet. Bed the nurse should have dent's refusal to get out of bed and notified the am (IDT) to conduct an sident. The DON further coots weren't worn and/or a positioned as scheduled, the exim breakdown. If Wound Care policy revised aff were to ensure residents lity received care to prevent in developing. The policy also orders and/or pressure terventions were to be a compromised skin integrity ontinence, Catheter, UTI 1)-(3) Inence. Facility must ensure that tinent of bladder and bowel on a services and assistance to be unless his or her clinical ones such that continence is	F 68			11/10/21
	5 (-/(-/- 3. 6.	,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	СОМ	(X3) DATE SURVEY COMPLETED C	
		245055	B. WING			30/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 690	comprehensive as ensure that- (i) A resident who indwelling catheter resident's clinical of catheterization wa (ii) A resident who indwelling catheter is assessed for rerias possible unless demonstrates that and (iii) A resident who receives appropriate prevent urinary tracontinence to the experience of the experienc	ed on the resident's sessment, the facility must enters the facility without an is not catheterized unless the condition demonstrates that is necessary; enters the facility with an or subsequently receives one moval of the catheter as soon at the resident's clinical condition catheterization is necessary; is incontinent of bladder atte treatment and services to ct infections and to restore	F 6	R186 had catheter cares dark urine reported to proving has been reviewed and reneeded. Policies and procedures reupdated as needed. Care plans for all residents catheters have been revieupdated as needed.	vider. Care plan vised as eviewed and s with indwelling		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245055	B. WING				30/2021
	PROVIDER OR SUPPLIER	H CENTER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 737 BRYANT AVENUE SOUTH IINNEAPOLIS, MN 55409	1 00/1	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	hygiene, bathing, ar wheelchair, and tota with assistance of 2 indicated a diagnos obstructive uropath indwelling foley cathological control of the control	and, eating, toileting, personal and ability to move his all dependence for transfers all dependence for transfers are people. The MDS also is of neurogenic bladder and y, requiring a long termineter. Idated 9/30/21, indicated a kidney disease, a history of ans, retention of urine, and ux uropathy. Immary Sheet dated 1/7/19, are was to be provided three er every bowel movement. Idated 5/28/21, indicated nurses are ening of urine color to the adicated to perform catheter after every bowel movement. Administration Record (MAR) after dated 8/10/21, from N)-J indicated R186 had a sen (UTI) with staphylococcus	F 6	90	Nursing staff will be educated regal catheter cares including the proper procedure for emptying and mainted. Monitoring for compliance will be electhrough random weekly observation audits for a minimum of 8 weeks. Facility QA&A Committee will review results and make further recommendations. Director of Nursing or designee will responsible for ensuring compliance.	nance. nsured nal w audit	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` ´coı	TE SURVEY MPLETED
		245055	B. WING _			/30/2021
	PROVIDER OR SUPPLIER	TH CENTER		STREET ADDRESS, CITY, STATE, ZIP 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 690	During observation R186's urine color dark brown color. If would be performe her. When interviewed reviewed the cather care plans. RN-H is required catheter of bowel movements, the care after the arest. During observation related R186 was stated she would assess signs (VS). Nursin room and assisted and reported to RN normally as dark astated when in douknow very well, she changes. During observation emptied R186's ca centimeters (cc) ou not clean the cather (where the urine exhave. NA-F emptie cylinder and left to When interviewed indicated the correuse an alcohol wip	age 27 In on 9/30/21, at 9:01 a.m. In the bag appeared to be a RN-H indicated catheter care In d by afternoon shift, and not by In on 9/30/21, at 1:34 p.m. RN-H Inter care orders, tasks, and Inter care orders, tasks,	F 69			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245055	B. WING			C 30/2021
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	because she did no again told RN-H she and his urine was n left the room withous ite. When interviewed cassistant director of aide should cleanse alcohol wipe after esecuring it back in pshould have follower infection. During record reviewed RN-H had not notification container end of the catheter Label/Store Drugs a CFR(s): 483.45(g) Labeling Drugs and biological labeled in accordant professional principappropriate accessinstructions, and the applicable. §483.45(h) Storage	ot have a alcohol wipe. NA-F e worked with R186's regularly ot normally that dark. NA-F at cleaning the catheter exit on 9/30/21, at 2:33 p.m. If nurses (ADON) indicated the e the catheter valve with an emptying the bag, and before blace. ADON stated the aide ed the policy to prevent UTI or w on 9/30/21, at 2:51 p.m. ed the provider about the dark cy, dated 5/1992, and revised to empty the bag into a and cleanse the cap at the connection. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be lice with currently accepted lies, and include the	F 6			11/10/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	` ′сом	E SURVEY PLETED
		245055	B. WING			C 30/2021
NAME OF F	PROVIDER OR SUPPLIER	<u>I</u>		STREET ADDRESS, CITY, STATE, ZIP		30,2021
WALKER	R METHODIST HEALT	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 761	§483.45(h)(2) The locked, permanent storage of controlle the Comprehensive Control Act of 1976 abuse, except whe package drug distr quantity stored is not be readily detected. This REQUIREME by: Based on observareview the facility for were stored and seresident (R474) which storage and labeling to remove expired maintain medication the appropriate ran	ols, and permit only authorized access to the keys. facility must provide separately ly affixed compartments for ed drugs listed in Schedule II of e Drug Abuse Prevention and and other drugs subject to in the facility uses single unit libution systems in which the ninimal and a missing dose can l. NT is not met as evidenced alled to ensure medications ecured safely for 1 of 20 no was reviewed for medication and in refrigerator temperatures in the latest and the provided in the provided in the facility failed or discontued medications and in refrigerator temperatures in the latest and the provided in the facility failed or discontued medications and the provided in the facility failed or discontued medications and discontinuous facility failed or discontinuou	F 76	R474 medications were rediscarded as needed. A whole house audit of memedication rooms and merefrigerators will be conducted to 11/10/21. All expired, implemedications will been remproperly destroyed.	edication carts, dication cted on or prior aproperly aperly stored	
	registered nurse (F nurse RN-M walke	tion on 9/30/21, at 8:09 a.m. RN)-M was observed to walked d away from the medication		Medication storage policy reviewed and remains app Licensed Nurses educated storage of medications income	oropriate. I on the proper luding ensuring	
	was left unlocked a top of the cart unat within five feet of th housekeeping staff cart. RN-M was aw cart for roughly 4 n	ter nurse. The medication cart and medications were left un tended. Two residents were ne unlocked cart and two f walked pasted the medication way from the medication and ninutes.		medications are not left un medications are dated at to opened, medications are of the time of discharge and temperature of medication. Monitoring for compliance through random weekly au medication carts and medication.	ime they are lisposed of at monitoring the refrigerators will be ensured idits of	

(X3) DATE SURVEY COMPLETED	
C 19/30/2021	
0.00,2021	
(X5) COMPLETION DATE	
t	
di	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 09/30/2021	
		245055				
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF STATE AND		700/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From pa	age 31	F 76	1		
	people at risk for a stated her expecta to secure medicati away. Facility's policy Me undated, indicated timely administration	medications out could put ccidental ingestion. ADON tion would be for nursing staff ons and cart before walking dication Storage in The Facility ensure accurate, safe, and on of drugs to our residents, estorage of supplies. The				
	facility's policy dire keys at all times w During an interview floor, odd side of h at 12:12 p.m. a box	cted the nurse to carry the cart hile on duty. v and observation of the fifth all, medication cart on 9/30/21, ttle of saline eye drops was				
	and birthdate on it. no date indicating Registered nurse (packaging with the medication cart. R when the eye drop	ame, medical record number, The bottle was half empty with when it was opened. RN)-Q verified the original pharmacy label was not in the N-Q stated he did not know s were opened and therefore, they would expire.				
	fifth-floor medication p.m. a bottle of liquid found in the refriger RN-Q stated had properties at the lorazepam was 8/11/21. The therm indicated the temperature should belonging to R455	v and observation of the on room on 9/30/21, at 12:26 aid lorazepam (a narcotic) was erator belonging to R422, whom eassed away, "awhile a go." is filled by the pharmacy on nometer in the refrigerator erature was 50 degrees verified the temperature and know what the correct die. Various insulin's R466 and R477 were in the would expire within 28 days of				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245055	B. WING		09/30/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		700/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 761	During an interview fourth-floor medicate p.m. a bottle of tub tuberculosis) had a stated she was una good for after it was be used for staff of A box of Tylenol suin the refrigerator was olution package in stored at 35-46 degood only 30 days. During an interview third-floor medicatin p.m. ertapenem (a date of 9/10/21, an expiration date of 9/10/21, an expiration date of 9/10/21, and expiration date of 9/10/21, and third-floor medication discharged from the refrigerator. Also of Aller-ease, a stock expiration date of 9/10/21, and third-floor medication for managers destroyed did not know the properties of the medication for fifth, fourth, and third-floor medicated 12/7/16, indicated 12/7	efrigerator temperature of brenheit. If and observation of the ation room on 9/30/21, at 12:50 perculin (injected to detect an open date of 7/26/21. RN-R usure how long tuberculin was as opened. The solution could any newly admitted residents. Appositories was also observed with an expiration date of sol Purified Protein Derivative ansert indicated it was to be grees Fahrenheit, and was after opening the solution. If and observation of the son room on 9/30/21, at 1:15 an antibiotic) with an expiration and an insulin pen with an application, which are facility, were found in the beserved was an opened box of allergy medication, with an application, with an application and RN-B was rocess. If it is a strength of the solutions and RN-B was rocess. If it is a strength of the solutions and RN-B was rocess. If it is a strength of the solutions and RN-B was rocess. If it is a strength of the solutions and RN-B was rocess. If it is a strength of the solutions and RN-B was rocess. If it is a strength of the solutions were to strength of the strength of th	F 76			
	The medication-real medication roor fifth, fourth, and the The facility Medica 12/7/16, indicated be immediately rerof according to pol	frigerator temperature logs for ins that were observed, (sixth, ird floors) were incomplete.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 09/30/2021	
		245055	B. WING			
	PROVIDER OR SUPPLIER	H CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		5072021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 761 F 880 SS=J	kept between 36-46 Infection Prevention CFR(s): 483.80(a)(§483.80 Infection C The facility must es	6 degrees Fahrenheit. n & Control 1)(2)(4)(e)(f)	F 76			11/10/21
	designed to provide comfortable environ development and to diseases and infection systems. The facility must estable comfortable to program.	e a safe, sanitary and nement and to help prevent the ransmission of communicable tions. In prevention and control stablish an infection prevention in (IPCP) that must include, at				
	reporting, investiga and communicable staff, volunteers, vi- providing services of arrangement based	d upon the facility assessment ng to §483.70(e) and following				
	procedures for the but are not limited t (i) A system of surv possible communic infections before th persons in the facil (ii) When and to wh communicable dise reported;	eillance designed to identify able diseases or ey can spread to other				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245055		B. WING		I	C 09/30/2021	
	PROVIDER OR SUPPLIER	TH CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		00/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	to be followed to pr (iv)When and how resident; including (A) The type and d depending upon th involved, and (B) A requirement t least restrictive pos circumstances. (v) The circumstan must prohibit empl disease or infected contact with reside contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A sy identified under the corrective actions t §483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual The facility will con IPCP and update tl This REQUIREME by: Based on observa review, the facility f resident who was r into quarantine and protective equipmed direct care was pro (R263) who require	revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility oyees with a communicable I skin lesions from direct ints or their food, if direct it the disease; and ne procedures to be followed direct resident contact. Istem for recording incidents a facility's IPCP and the aken by the facility. Indle, store, process, and as to prevent the spread of	F 880	R263 was identified with a ye band and was placed on COV quarantine precautions per CI guidelines. All residents residing on the at were tested for COVID-19 on All were found to be negative.	TID DC ffected unit 09/27/2021.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
	245055 B. WING			C 09/30/2021		
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		STREET ADDRESS, CITY, STATE, ZIP CO	•	30/2021
				3737 BRYANT AVENUE SOUTH		
WALKER METHODIST HEALTH CENTER			MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		HOULD BE	(X5) COMPLETION DATE		
F 880	was to be on TBP	age 35 ediate jeopardy (IJ) when R236 and staff did not follow the n to the resident in immediate	F 88	Facility COVID Observation F Procedure was reviewed and	•	
	consistently wore f and mouth and eye preventing the spre staff (NA-K, NA-J, source control mea failed to perform ha	ry failed to ensure staff ace masks covering the nose of protection to aide in lead of COVID-19 for 4 of 22 NA-E and RN-L) observed for asures. In addition, the facility and hygiene when providing 1 of 10 residents (R61) anal cares.		Staff of all disciplines were ed 09/27/21 and ongoing related a yellow wrist band to identify residents on active COVID Q and the need to re-direct quaresidents to their room if they break quarantine.	to the use of those uarantine rantined should	
	was in the dining roother residents, ph not wear gloves or therapy room and wearing appropriat director of nursing 9/28/21, at 4:30 p.r corrective actions or removed on 9/29/2 noncompliance rer severity level of a I level, which indicat	27/21, at 1:56 p.m. when R263 com, unmasked and close to ysical therapy aide (PTA)-A did gown, brought R263 to the worked with her without e PPE. The administrator and (DON) was notified of the IJ on m. The facility implemented on 9/29/21. The IJ was 11, at 11:53 a.m., but mained at the lower scope and D - isolated scope and severity than minimal harm that is not y.		All staff also received education 9/27/21 related to hand hygie the appropriate PPE to care from Quarantine. Staff of all disciplines will be ron or before 11/10/21 on the PPE to wear in patient care a COVID-19 pandemic continuous Monitoring for compliance will through random weekly audit admitted unvaccinated reside quarantine. These audits will a minimum of 8 weeks.	ne and on or a resident re-educated appropriate reas while res. I be ensured s of newly ents on continue for	
	guidance for COVI long term care incl residents who are readmissions shou quarantine, even if admission." The gu	r for Disease Control (CDC) D-19 with new admissions to ude: "All unvaccinated new admissions or lld be placed in a 14-day they have a negative test upon uidance also requires staff to protective equipment (PPE),		Random daily audits will also conducted for 14 days then weeks to ensure all staff are with wearing all appropriate Facility QAPI Committee will results and make further recommendations. Director of Nursing or designation	reekly for 6 compliant PPE in patient review audit	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245055	B. WING _			/30/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	N95 or higher-leve 14 day quarantine R263's admission dated 9/25/21, incompairment, had a extensive staff asswas not on isolation infection. R236's Admission been admitted on vaccinated against register requires to related to potential exposure for the frand/or an actual president requires to related to potential exposure for the frand/or an actual president requires to related to potential exposure for the frand/or an actual president were directed preconditional process. Were directed precourage patient areas. Wear observable socially distance reshift until 10/4/21.	Minimum Data Set (MDS) Iluded severe cognitive hip fracture and required sistance for locomotion. R263 on or quarantine for an active Record identified R236 had 9/20/21, and had not been t COVID-19. dated 9/20/21, included, "The ransmission based precautions I pre-admission COVID-19 rst 14 days from admission ositive COVID-19 test result." d, "Follow DROPLET when caring for this resident." order summary dated 9/28/21, on observation until 10/4/21. It to wear mask in common rvation PPE with close contact. esident at meal times, every	F 88	DEFICIENCY)		
	Group 1, dated 9/2 on observation un During observatio was in the dining I was not wearing a (PTA)-A entered the	sistant worksheet, 3 Gamble 24/21, included R263 was to be til 10/4/21. In on 9/27/21, at 1:56 p.m. R263 room with other residents and mask. Physical therapy aide, ne dining room and took R263 m and transferred her to an				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
		245055	B. WING		09/30/2021		
	PROVIDER OR SUPPLIER R METHODIST HEAL			STREET ADDRESS, CITY, STATE, ZIP CO 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		, 33/34/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	exercise table with assisted R263 with up and ambulated several other resid a mask to wear an or gloves. During observation was at the dining resident, neither resource control and When interviewed stated R263 was oprecautions (TBP) that was not vaccin stated there should allows the staff to on and what PPE troom did not indicaprecautions. During observation PTA-B took R263 therapy room and without wearing a sambulated R263 in and holding onto the R263 in close distant did not have a massession. Directly a went into R500's rewith the resident. It mask and eye professions. Further was precautions. Further was precautions.	no gown or gloves on. PTA-A table exercises, then assisted R263 in the hallway around ents. R263 was never offered d PTA-A never put on a gown on 9/28/21, at 8:19 a.m. R263 com table with another esident wore a face mask for they were not 6 feet apart. on 9/28/21, at 8:29 a.m. RN-A on transmission based due to being a new admission nated for COVID-19. Further, d be a sign on the door that know what TBP the resident is to use. The door to R236's ate she was on any sort of an on 9/28/21, at 9:23 a.m. from the dining room into the completed leg exercises gown or gloves. Further, PTA-B on the hallway using a walker the gait belt while ambulating ance of 5 other residents. R263 sk on throughout the therapy fiter working with R263, PTA-B com and completed exercises PTA-B wore the same clothing, tection as they did with R263. on 9/28/21, at 9:45 a.m. PTA-B are of R263 being on any type of the resident of the room and PPE such and the proof of the room and PPE such	F 88	30			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING) COM	(X3) DATE SURVEY COMPLETED	
		245055	B. WING				C / 30/2021	
	PROVIDER OR SUPPLIER	H CENTER		3737 BRYAN	RESS, CITY, STATE, ZIP COD I t avenue south D lis, MN 55409	•	700/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	PROVIDER'S PLAN OF CORRE CH CORRECTIVE ACTION SH SS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	as a gown and glow while working with During observation R263 was sitting in residents with no modes of the residents with no modes of the resident of the res	on 9/28/21, at 10:17 a.m. the TV room with 5 other mask on. All residents were stated the therapy staff should on precautions in the room if irector of therapy stated the low who is on precautions by a ts door. on 9/28/21, at 11:10 a.m. fection preventionist (RN)-B admitted who was not fully coinated, was to be placed on tions and full personal int (PPE) was to be worn since have COVID-19, such as k, and eyewear. Secondly, servation and isolation rooms lation cart at the doorway with the drawer to indicate what for the resident and what TBP Further, RN-B stated therapy is on precautions and what PPE their treatment plan, There in the treatment plan, There in the signs by the doors. It is a sign or cart by her bedroom and R263 had not been COVID-19 and should have a 14 day quarantine, which	F 8	30				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245055	B. WING _			C / 30/2021
	PROVIDER OR SUPPLIER	TH CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		70072021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	was sitting in the Tother residents. All each other. When interviewed nursing assistant (I aware R263 was s NA-A stated R263 wear a mask if ask When interviewed stated they did not quarantined or encout of the room too be quarantined to rout of room should mask. When interviewed licensed practical root made any atterroom because, "thi The facility Screen resident infection pindicated the purpor COVID-19 is to gui and to prevent the indicated a resident testing positive for vaccinated, would and be quarantined. The PPE Requirem Infection Control P	V room with no mask on with 5 residents were within 6 feet of on 9/28/21, at 1:36 p.m. NA)-A stated they were not till on quarantine precautions. was cooperative and would ed. on 9/28/21, at 1:38 p.m. RN-C know why R263 had not been ouraged to wear a mask while lay. RN-C verified R263 should room and if needed to come be encouraged to wear a on 9/28/21, at 1:50 p.m. hurse (LPN)-B stated they had mpt to quarantine R263 in her is a dementia unit." ing and Surveillance of deappropriate interventions spread of COVID-19. Further, at that doesn't have a history of COVID-19, or is not fully be placed in a private room of the for Health Care Workers olicy dated 6/28/21, indicated	F 88	30		
	The facility Screen resident infection pindicated the purportion of the purport of the purport of the purport of the prevent the indicated a resident testing positive for vaccinated, would and be quarantined. The PPE Requirent Infection Control Peye protection, make worn for resider	ing and Surveillance of prevention policy dated 8/30/21, use of the surveillance of de appropriate interventions spread of COVID-19. Further, at that doesn't have a history of COVID-19, or is not fully be placed in a private room d for 14 days.				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
245055			B. WING_		09/30/2021		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	9/29/21, after the faplan which included residents on the aft COVID-19, the fact policy, all residents signage placed on placed, staff were for education prior Verification of imple	n on 9/27/21, was removed on acility implemented a removal d the following actions: all fected unit were tested for ility updated their observation on quarantine/isolation had door, a yellow wrist band educated and notified of need to working next shift. ementation of the removal plan observation, interview and	F 88	30			
	nursing assistant N meals wearing mas was not wearing ey interviewed NA-K son his eye protection be over his nose. During an observation	tion on 9/28/21, at 8:45 a.m. IA-K was observed delivering sk under nose his nose and reprotection. When stated he had forgotten to put on and knew his mask should tion nursing on 9/28/21 at 8:52 a resident's room with no eye					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245055	B. WING		1)/2021
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409	1 33/33/232	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	During an observal NA-E was observed entering residents interviewed NA-E agoggles and was a During observation had goggles on do covering her eyes, time wearing the goggles and ward. Ron wearing the goggles dok downward. Ron wearing the goggles on wearing the goggles of tooler tooler wearing observation entered R61's room and applied barried then without remoth hygiene applied a the covers over R6 control on the residuals to R61. Then performed hand hystated she should washed her hands tasks. During an interview director of nursing perform hand hygiclean during reside goggles.	age 41 Ition on 9/28/21, at 8:53 a.m. In on 9/28/21, at 8:58 a.m. RN-L In on 9/28/21, at 9 a.m. RN-L In on 9/28/21, indicated In 14 with intact cognition. The In on 9/27/21, at 1:09 p.m. NA-L In on	F 880			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED C 09/30/2021	
		245055	B. WING			
	PROVIDER OR SUPPLIER	H CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 921 SS=D	The DON stated st wash their hands o on new gloves before the facility Hand Hindicated staff shout touching body subscontaminated object bedpans, basins, or Safe/Functional/SaCFR(s): 483.90(i) §483.90(i) Other End The facility must propose sanitary, and comform residents, staff and This REQUIREMED by: Based on observative, the facility for feeding tube poleand R150) resident Findings include: R58's quarterly Min 7/27/21, included so and received a tube During an observative bottle of tube feeding metal pole and for gastric tube. The mindings include.	aff should remove their gloves, r use hand sanitizer, then put ore continuing with cares. ygiene policy dated 6/1/19, and perform hand hygiene after stances and any potentially cits, such as dressings, alothing, or linen and so forth. Initary/Comfortable Environ novironmental Conditions ovide a safe, functional, portable environment for a the public. NT is not met as evidenced ation, interview, and document failed to ensure the cleanliness es for 2 of 3 residents (R58 as reviewed for tube feeding.	F 880		I as tion eral ured re	
	drippings on the fac	here was also dried formula ce of the pump. ion and interview on 9/29/21,		Facility QAPI Committee will review at results and make further recommendations.	udit	

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

PRINTED: 11/12/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		245055	B. WING		09	C / 30/2021
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
WALKER	R METHODIST HEAI	TH CENTER		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 921	R58's room to pe stated the dried for pole and pump sh considered sanital R150's R150's an included cognitive feeing. During an observat 10:53 a.m. a 15 formula with tubir from a metal pole drippings of dried dried splatter of for pole. Also observ formula across the pump. RN-P acknowled the equipment and should have been any staff member equipment.	stered nurse (RN)-O entered rform gastric tube cares. RN-O ormula on R58's tube feeding nould not be there and was not ary. Inual MDS dated 8/26/21, ely intact and received a tube ation and interview on 9/28/21, 500 ml bottle of tube feeding a gattached, was found hanging a next to R150's bed. Multiple formula ran down the pole and ormula was on the base of the ed were drippings of dried e face of the tube feeding nowledged the dried formula on d stated it was not sanitary and a cleaned. RN-P further stated it could have cleaned the	F 9	Director of Nursing or desi responsible for ensuring or		
	During an observation on 9/29/21, at 7:35 a.m. tube feeding pole in R150's room had dried tube feeding formula on the pole, base, electrical cord, and pump.					
	the same dried for	ation on 9/29/21, at 2:30 p.m. rmula drippings and splatter the pole, base, electrical cord, 0's room.				
	director of nursing splatter from tube been cleaned up	ew on 9/30/21, at 1:54 p.m. the g (DON) stated drippings and feeding formula should have immediately by the nurse tube feeding and should not				

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

PRINTED: 11/12/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	COV	E SURVEY MPLETED
		245055	B. WING			C / 30/2021
	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409		00/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 921	have been left to dr further stated dried not sanitary.	y for multiple days. The DON formula on equipment was	F 9	721		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 26, 2021

Administrator Walker Methodist Health Center 3737 Bryant Avenue South Minneapolis, MN 55409

Re: State Nursing Home Licensing Orders

Event ID: WQHW11

Dear Administrator:

The above facility was surveyed on September 27, 2021 through September 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

Walker Methodist Health Center October 26, 2021 Page 2

"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:

Karen Aldinger, Unit Supervisor St. Cloud A District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: karen.aldinger@state.mn.us

Office: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit

Walker Methodist Health Center October 26, 2021 Page 3

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00276	B. WING			C 09/30/2021	
		00276	B. WIIVO		09/3	30/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU POLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the corrected requires of the number and MN Ruwhen a rule contain comply with any of the foundation of the comply with any of the pursuant of the comply with any of the foundation of the complex with any of the contains the complex with any of the contains the complex with any of the contains the complex with the contains the con	nether a violation has been					
	re-inspection with a result in the assess	ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.					
	was conducted at y the Minnesota Depa facility was found N State Licensure and orders are issued. I electronic plan of co	rs: n 9/30/21, a licensing survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN d the following correction Please indicate in your orrection you have reviewed					
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

Electronically Signed 11/05/21

STATE FORM 6899 If continuation sheet 1 of 32 WQHW11

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.			c
		00276		B. WING			30/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER		ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1		2 000			
	these orders, and in the completed.	dentify the da	te when they will				
	The following complaints were found to be unsubstantiated:						
	H5055303C (MN58 (MN66507), H5505 (MN63946), H5055 (MN52812), H5055 (MN56183), H5055 (MN59811), H5055 (MN64286), H5055	305C (MN52 302C (MN62 293C (MN54 295C (MN57 297C (MN64 301C (MN67	293), H5055300C 631), H5055294C 624), H5055296C 004), H5055304C 144), H5055297C 221)				
	The following complaints were found to be substantiated with NO deficiencies issued due to corrective actions taken by the facility prior to survey:						
	H5055306C (MN76946)						
	Minnesota Departmenthe State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far leading." The state stallisted in the "Summer column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Column to State 1.	Correction Cag numbers had numbers had assigned to the assigned to the assigned to the ary Statement of the are in violation the are in violation the substance of Correction.	Orders using nave been tutes/rules for ag number ntitled " ID Prefix of compliance is nt of Deficiencies" mply" portion of n also includes n of the state is Rule is not met urveyors findings orrection and				
	You have agreed to receipt of State lice						

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 2 of 32

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DA		
		00276	B. WING		C 09/30/2021
	PROVIDER OR SUPPLIER	H CENTER 3737 B	ADDRESS, CITY, RYANT AVENU APOLIS, MN &		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	http://www.health.si obul.htm The State delineated on the a Department of Hea you electronically. is necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to elementary PLEASE DISREGATE FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/in elicensing orders are ttached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the ment of Health. ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY, R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF	n or		
2 835	Proper Nursing Car Subp. 2. Criteria for proper care. The cadequate and proper Evidence of adequate considerate treatments be respected and second	or determining adequate and criteria for determining er care include: ate care and kind and lent at all times. Privacy mus	2 835		11/10/21
	by: Based on observati	ion, interview, and document ailed to ensure urinary		Correction date on or before 11/10/202	1

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 3 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00276	B. WING			C 30/2021
	PROVIDER OR SUPPLIER	H CENTER 3737 BRY	ORESS, CITY, S ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 835	catheter care was prontamination and (UTI) for 1 of 3 residual catheter cares. Findings include: R186's annual Mini 9/1/21, indicated Rassistance with one bed mobility, dressi hygiene, bathing, at wheelchair, and tota with assistance of 2 indicated a diagnos obstructive uropath indwelling foley catholicated a diagnosis of chronicurinary tract infection obstructive and reflection obstructive and reflection of the care of 2 indicated catheter of times daily, and after the care every shift and R186's Medication and also in care every shift and R186's Medication and also in care every shift. R186's Provider No.	provided, to prevent potential urinary tract infection dents (R186) reviewed for mum Data Set (MDS) dated 186 required extensive person physical assist for ng, eating, toileting, personal nd ability to move his all dependence for transfers people. The MDS also is of neurogenic bladder and y, requiring a long term neter. Idated 9/30/21, indicated to kidney disease, a history of ons, retention of urine, and ux uropathy. Inmary Sheet dated 1/7/19, care was to be provided three per every bowel movement. Idated 5/28/21, indicated nurses the indicated to perform catheter and after every bowel movement. Administration Record (MAR) of the dated 8/10/21, from	2 835			
		N)-J indicated R186 had a on (UTI) with staphylococcus pleted an antibiotic.				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 4 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00276	B. WING		I	C 30/2021
	PROVIDER OR SUPPLIER R METHODIST HEALT	H CENTER 3737 B	ADDRESS, CITY, S RYANT AVENU APOLIS, MN 5	E SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 835	•	ge 4 e 100 milligrams (mg) that wa	2 835			
		daily for 7 days, prescribed f				
	indicated nurses do	on 9/29/21, at 2:30 p.m. RNo the catheter changes for care was scheduled every	-1			
	R186's urine color i dark brown color. F	on 9/30/21, at 9:01 a.m. in the bag appeared to be a RN-H indicated catheter cared by afternoon shift, and not	by			
	reviewed the cather care plans. RN-H s required catheter catheter catheren sowel movements,	on 9/30/21, at 1:34 p.m. RN- ter care orders, tasks, and tated she did not know R186 are 3 times a day and with and stated she would provid ide assisted R186 into bed to	e			
	related R186 was vestated she would reshift, and push fluid she would assess Figns (VS). Nursing room and assisted and reported to RN normally as dark as stated when in doubter stated	on 9/30/21, at 1:42 p.m. RN ery susceptible to UTI and eport the dark urine to the nels if she could. RN-H indicate R186's temperature and vital g assistant (NA)- F was in th with R186's personal cares -H 186's urine was not it was at that time. RN-H bt about a resident she did ne should notify a provider of	xt ed e			
	emptied R186's cat centimeters (cc) ou	at 9/30/21, at 1:42 p.m. NA- heter bag with 350 cubic tput. After cleaning NA-F dic ter outflow drainage port				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 5 of 32

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE MINNEAPOLIS, MN 55409 (X5)		NT OF DEFICIENCIES I OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 835 Continued From page 5 (where the urine exits the bag) as she should have. NA-F emptied the urine from the graduated cylinder and left to perform hand hygiene. When interviewed 9/30/21, at 1:44 p.m. NA-F indicated the correct way to empty the bag was to use an alcohol wipe on the catheter exit site to prevent infection, and related she did not do it because she did not have a alcohol wipe. NA-F again told RN-H she worked with R186's regularly and his urine was not normally that dark. NA-F left the room without cleaning the catheter exit site. When interviewed on 9/30/21, at 2:33 p.m. assistant director of nurses (ADON) indicated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should have followed the policy to prevent UTI or infection. During record review on 9/30/21, at 2:51 p.m. RN-H had not notified the provider about the dark urine color.								С
WALKER METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 835 Continued From page 5 (where the urine exits the bag) as she should have. NA-F emptied the urine from the graduated cylinder and left to perform hand hygiene. When interviewed 9/30/21, at 1:44 p.m. NA-F indicated the correct way to empty the bag was to use an alcohol wipe on the catheter exit site to prevent infection, and related she did not do it because she did not have a alcohol wipe. NA-F again told RN-H she worked with R186's regularly and his urine was not normally that dark. NA-F left the room without cleaning the catheter exit site. When interviewed on 9/30/21, at 2:33 p.m. assistant director of nurses (ADON) indicated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag and before se			00276		B. WING		09/	30/2021
(x4) ID PREFIX TAGE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (A) ID PREFIX (EACH DEFICIENCY) WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 835 Continued From page 5 (where the urine exits the bag) as she should have. NA-F emptied the urine from the graduated cylinder and left to perform hand hygiene. When interviewed 9/30/21, at 1:44 p.m. NA-F indicated the correct way to empty the bag was to use an alcohol wipe on the catheter exit site to prevent infection, and related she did not do it because she did not have a alcohol wipe. NA-F again told RN-H she worked with R186's regularly and his urine was not normally that dark. NA-F left the room without cleaning the catheter exit site. When interviewed on 9/30/21, at 2:33 p.m. assistant director of nurses (ADON) indicated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should have followed the policy to prevent UTI or infection. During record review on 9/30/21, at 2:51 p.m. RN-H had not notified the provider about the dark urine color.	NAME OF	PROVIDER OR SUPPLIER						
### (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 835 Continued From page 5 2 835 (where the urine exits the bag) as she should have. NA-F emptied the urine from the graduated cylinder and left to perform hand hygiene. When interviewed 9/30/21, at 1:44 p.m. NA-F indicated the correct way to empty the bag was to use an alcohol wipe on the catheter exit site to prevent infection, and related she did not do it because she did not have a alcohol wipe. NA-F again told RN-H she worked with R186's regularly and his urine was not normally that dark. NA-F left the room without cleaning the catheter exit site. When interviewed on 9/30/21, at 2:33 p.m. assistant director of nurses (ADON) indicated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should have followed the policy to prevent UTI or infection. During record review on 9/30/21, at 2:51 p.m. RN-H had not notified the provider about the dark urine color.	WALKER	R METHODIST HEALT	H CENTER					
(where the urine exits the bag) as she should have. NA-F emptied the urine from the graduated cylinder and left to perform hand hygiene. When interviewed 9/30/21, at 1:44 p.m. NA-F indicated the correct way to empty the bag was to use an alcohol wipe on the catheter exit site to prevent infection, and related she did not do it because she did not have a alcohol wipe. NA-F again told RN-H she worked with R186's regularly and his urine was not normally that dark. NA-F left the room without cleaning the catheter exit site. When interviewed on 9/30/21, at 2:33 p.m. assistant director of nurses (ADON) indicated the aide should cleanse the catheter valve with an alcohol wipe after emptying the bag, and before securing it back in place. ADON stated the aide should have followed the policy to prevent UTI or infection. During record review on 9/30/21, at 2:51 p.m. RN-H had not notified the provider about the dark urine color.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PREC	EDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE
8/1/2013, indicated to empty the bag into a collection container and cleanse the cap at the end of the catheter connection. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for proper catheter care. Nursing staff could be educated on proper catheter care. The DON or designee, could perform audits to ensure compliance. The DON or designee could take that information to QAPI to ensure compliance	2 835	(where the urine exhave. NA-F emptie cylinder and left to When interviewed indicated the correcuse an alcohol wipe prevent infection, a because she did not again told RN-H shand his urine was releft the room withous site. When interviewed assistant director of aide should cleans alcohol wipe after esecuring it back in should have follower infection. During record revies RN-H had not notification. Catheter Care Police 8/1/2013, indicated collection containered of the catheter SUGGESTED MET administrator, direct designee could rever proper catheter care educated on prope designee, could pecompliance. The Decompliance.	cits the bag) at the urine from perform hand 19/30/21, at 1:4 of way to empty on the catheter that cleaning the bar of have a alcoope worked without normally that cleaning the bar of have a hand cleaning the bar of have a hand cleaning the bar of have and cleaning the bar of having the connection. THOD OF CO of the bar of having the bar of having the bar of having the connection. THOD OF CO of the bar of having the	om the graduated hygiene. 14 p.m. NA-F ty the bag was to exter exit site to e did not do it hol wipe. NA-F n R186's regularly nat dark. NA-F e catheter exit 12:33 p.m. DN) indicated the evalve with an bag, and before stated the aide o prevent UTI or at 2:51 p.m. er about the dark 192, and revised bag into a the cap at the 1RRECTION: The (DON) or e policies for aff could be e. The DON or o ensure ee could take	2 835			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 6 of 32

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY		
		00276		B. WING		1	C 8 0/2021
NAME OF F	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
WALKER	METHODIST HEALT	H CENTER		ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG		TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 6		2 835			
	education/monitoring	ng/compliance.					
	TIME PERIOD FOR	R CORRECTIO	N: (21) days.				
2 905	MN Rule 4658.0525	5 Subp. 4 Reha	b - Positioning	2 905			11/10/21
	Subp. 4. Positionin positioned in good lof residents unable must be changed a including periods of been put to bed for has documented th hours during this tir the physician has o	body alignment. to change their t least every two f time after the r the night, unles at repositioning ne period is un	The position own position o hours, resident has as the physician every two necessary or				
	This MN Requirement by: Based on interview review, the facility fainjury measures to development of preresidents (R58) rev	, observation, a ailed to impleme minimize the ris ssure injuries fo	nd document ent pressure k for the or 1 of 3		Correction date on or before 11/1	0/2021	
	Findings include:						
	R58's quarterly Min 7/27/21, included so with diagnoses included a stoke with hemipl paralysis on one sid staff assistance with dressing and did no risk for pressure uld	evere cognitive uding, diabetes, egia/paresis (w de). R58 require h bed mobility, h ot refuse cares.	impairment dementia and eakness or d extensive nygiene and				
	R58's care plan dat an activities of daily Interventions indica	living (ADL) de	ficit.				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 7 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER	` '	E CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		I	C 30/2021
	PROVIDER OR SUPPLIER R METHODIST HEALT	H CENTER 373	EET ADDRESS, CITY, 7 BRYANT AVENU INEAPOLIS, MN 5	E SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 905	wheelchair after brebefore lunch. The chave Prevalon boot the heels to preven feet. The care plan turn/reposition R58 heel lift boots shoul times. The care plan be checked and chefore lunch. The chad a potential for Interventions include for the prevention encourage small, fround administer all trees. S's Kardex (nurs 9/16/21, indicated Feed mobility and she every 2-3 hours with R58's Order Summ R58 should have have feet, every shift, for R58's Provider Propindicated R58 was Prevalon boots, and pillows. R58's Provider Propindicated R58 was Prevalon boots, and pillows, with minimal extremeties.	eakfast and back into bed care plan indicated R58 wits (special boots that off-let pressure on them) on be also indicated to every two to three hours in indicated R58's brief water anged after breakfast and care plan further indicated pressure ulcer development and to follow facility protocoff skin breakdown, to requent position changes, atments as ordered. The aide worksheet) dated R58 required a total assisticuld have been reposition hoots applied to R58's for any dated 1/3/20, indicated and Prevalon boots on both wound prevention. The gress Note dated 7/15/21 bying in bed, not wearing different processing the latest were not floated of all movement of right.	as to coad coth and II as to cols and II as to c			
	on 9/29/21 from 9:3 supine in bed at a 3	and continuous observat 34 a.m. to 10:10 a.m. R58 30-degree angle with the de blinds closed. R58 did	s was			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 8 of 32

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00276	B. WING		09/3	0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU			
		MINNEAP	OLIS, MN 5	5409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 8	2 905			
2 905	have Prevalon boof pressure injuries) of pressure injury prevalon boof pressure injury prevalon to changed his brit woke up at an unkraction 10:10 a.m. registers. R58's room to discon RN-O left R58's room to discon RN-O left R58's room pressure in bed at the ordered Prevalon stated staff had still brief or reposition hunknown time. At 1 (NA)-L entered R58 R58's closet, then hunch. NA-L did not R58. At 12:00 p.m. 12:01 p.m. NA-M end at the prevalon p.m. RN-O entered feeding tube then bed at a 30-degree his feet. At 12:15 p. room and applied entered in the pressure relieving to p.m.	is (a soft boot worn to prevent in his feet as ordered for vention. R58 stated staff had effor repositioned him since he lown time that morning. At ead nurse (RN)-O entered ontinue the tube feeding. In without repositioning R58. and continuous observation 0:37 a.m. to 12:45 p.m. R58 at a 30-degree angle without on boots on his feet. R58 not been in to change his im since he woke up at an 1:00 a.m. nursing assistant its room, put a bag of briefs in efft, stating she was going to provide care or reposition R58 activated his call light. At intered R58's room. NA-M isplaced his television remote 8's lap and left the room. ition or change R58's brief or boots to R58's feet. At 12:09 R58's room to flush R58's eft. R58 remained supine in angle with no boots applied to m. RN-O returned to R58's ye drops to R58's eyes then oning R58. R58 was observed 30-degree angle with no boots on his feet until 12:45	2 905			
	NA-L stated resider their briefs checked she had not reposit	on 9/29/21, at 12:46 p.m. hts should be repositioned and I every two hours. NA-L stated ioned or checked R58's brief a.m. or 8:30 a.m. NA-L stated				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 9 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00276	B. WING		I	C 30/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
\A/A 1/FF	METHODIOT HEALT	3737 BR	YANT AVENUE	SOUTH		
WALKER	R METHODIST HEALT	H CENTER MINNEA	POLIS, MN 55	5409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 9	2 905			
2 905	she would go back NA-L further stated contracted if he was frequently. NA-L stated care sheet indicated boots, but that R58 night and often kick. During an interview RN-O stated reside and their briefs che skin breakdown. During an observati at 1:06 p.m. RN-O at to provide pericare and NA-L reposition Prevalon boots out them to R58's feet. circular, red spot as in diameter to his le not seen the red spouring an observati R58 was supine in Prevalon boots wer blanket. During an interview director of nursing (follow each residen schedule. The DON order for Prevalon is the boots should hat The DON also states	to assist R58 after lunch. R58 could get "bed sores" or a not repositioned or changed ated she did not know what the diregarding the Prevalon preferred to wear them at ted them off during the day. on 9/29/21, at 1:00 p.m. Into should be repositioned cked every two hours to avoid aton and interview on 9/29/21, and NA-L entered R58's room and change R58's brief. RN-Coned R58 in bed. NA-L took the of R58's closet and applied R58 had a blanchable, proximately three centimeters of theel. RN-O stated she had not on R58's heel previously. Sinn on 9/30/21, at 4:20 p.m. bed, visiting with family. R58's e on R58's wheelchair under a no 9/30/21, at 1:54 p.m. the DON) stated staff should t's changing and repositioning a stated if a resident had an poots to be applied every shift, ave been on the resident's feet and the nurse should have dent's refusal to get out of bed				
	evaluation of the re	am (IDT) to conduct an sident. The DON further				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 10 of 32

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SUR COMPLETE	
		00276	B. WING		C 09/30/2 ()21
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU			
		MINNEAL	POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CC	(X5) DMPLETE DATE
2 905	Continued From page 10		2 905			
	resident was not repositioned as scheduled, the resident could have skin breakdown.					
	8/1/19, indicated standard admitted to the faci pressure ulcers from indicated physician relieving nursing interest.	d Wound Care policy revised aff were to ensure residents lity received care to prevent m developing. The policy also orders and/or pressure reventions were to be a compromised skin integrity				
	The director of nurs review, revise, and procedures to ensuring a timely manner are in place, based needs. The DON or on the policies and audits to ensure on	THOD OF CORRECTION: sing (DON) or designee could implement policies and re residents are repositioned and pressure relieving devices upon residents' assessed designee could educate staff procedures and conduct going compliance.				
21375) Subp. 1 Infection Control;	21375		11/	10/21
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observati	ent is not met as evidenced on, interview, and record ailed to place a newly admitted		Correction date on or before 11/10/	2021	

Minnesota Department of Health STATE FORM

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 (X4) ID PREFIX TAG COMPLETED SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TO CONTINUED FROM the Appropriate DEFICIENCY Into quarantine and failed to ensure personal protective equipment (PPE) was used when direct care was provided for 1 of 4 residents (R263) who required transmission based precautions (TBP). This deficient practice resulted in an immediate jeopardy (IJ) when R236 was to be on TBP and staff did not follow the practice. In addition to the resident in immediate jeopardy, the facility failed to ensure staff		NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WALKER METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION YOR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 21375 Continued From page 11 resident who was not vaccinated for COVID-19 into quarantine and failed to ensure personal protective equipment (PPE) was used when direct care was provided for 1 of 4 residents (R263) who required transmission based precautions (TBP). This deficient practice resulted in an immediate jeopardy (IJ) when R236 was to be on TBP and staff did not follow the practice. In addition to the resident in immediate					A. BUILDING.		ے	•
WALKER METHODIST HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			00276		B. WING			
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21375 Continued From page 11 resident who was not vaccinated for COVID-19 into quarantine and failed to ensure personal protective equipment (PPE) was used when direct care was provided for 1 of 4 residents (R263) who required transmission based precautions (TBP). This deficient practice resulted in an immediate jeopardy (IJ) when R236 was to be on TBP and staff did not follow the practice. In addition to the resident in immediate	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21375 Continued From page 11 resident who was not vaccinated for COVID-19 into quarantine and failed to ensure personal protective equipment (PPE) was used when direct care was provided for 1 of 4 residents (R263) who required transmission based precautions (TBP). This deficient practice resulted in an immediate jeopardy (IJ) when R236 was to be on TBP and staff did not follow the practice. In addition to the resident in immediate	WALKER	R METHODIST HEALT	'H CENTER					
resident who was not vaccinated for COVID-19 into quarantine and failed to ensure personal protective equipment (PPE) was used when direct care was provided for 1 of 4 residents (R263) who required transmission based precautions (TBP). This deficient practice resulted in an immediate jeopardy (IJ) when R236 was to be on TBP and staff did not follow the practice. In addition to the resident in immediate	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PREC	CEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
consistently wore face masks covering the nose and mouth and eye protection to aide in preventing the spread of COVID-19 for 4 of 22 staff (NA-K, NA-J, NA-E and RN-L) observed for source control measures. In addition, the facility failed to perform hand hygiene when providing personal cares for 1 of 10 residents (R61) observed for personal cares. The IJ began on 9/27/21, at 1:56 p.m. when R263 was in the dining room, unmasked and close to other residents, physical therapy aide (PTA)-A did not wear gloves or gown, brought R263 to the therapy room and worked with her without wearing appropriate PPE. The administrator and director of nursing (DON) was notified of the IJ on 9/28/21, at 4:30 p.m. The facility implemented corrective actions on 9/29/21. The IJ was removed on 9/29/21, at 11:53 a.m., but noncompliance remained at the lower scope and severity level of a D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The current Center for Disease Control (CDC) guidance for COVID-19 with new admissions to long term care include: "All unvaccinated"	21375	resident who was no into quarantine and protective equipme direct care was pro (R263) who require precautions (TBP). resulted in an immediate was to be on TBP as practice. In addition jeopardy, the facility consistently wore far and mouth and eye preventing the sprestaff (NA-K, NA-J, I source control mean failed to perform has personal cares for observed for personal cares for observed for personal cares for other residents, physical not wear gloves or therapy room and wearing appropriate director of nursing 19/28/21, at 4:30 p.n. corrective actions or removed on 9/29/2 noncompliance removed on 9/29/2 noncompliance removed on 9/29/2 noncompliance removed in potential for more transportant of the current center guidance for COVIII of t	not vaccinated a failed to ensent (PPE) was evided for 1 of ed transmission. This deficience ediate jeopard and staff did rand to the reside y failed to ensead of COVID NA-E and RN asures. In add and hygiene wasures. In a 1:56 pom, unmaske ysical therapy gown, brough worked with he PPE. The and (DON) was not in the facility on 9/29/21. The significant at the D - isolated so ed no actual hean minimal by.	sure personal sused when f 4 residents on based at practice dy (IJ) when R236 not follow the ent in immediate sure staff overing the nose of aide in 19-19 for 4 of 22 I-L) observed for dition, the facility when providing ents (R61) So p.m. when R263 and close to y aide (PTA)-A did not R263 to the er without administrator and otified of the IJ on y implemented the IJ was m., but lower scope and severity harm with tharm that is not Control (CDC) wadmissions to				

Minnesota Department of Health STATE FORM

STATE FORM 6899 WQHW11 If continuation sheet 12 of 32

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00276	B. WING		09/3) 0/2021
NAME OF I	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	1 03/0	0/2021
	R METHODIST HEALT	3737 BRY	ANT AVENU			
		MINNEAP	OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 12	21375			
	quarantine, even if admission." The gu wear full personal pincluding gowns, gli N95 or higher-level 14 day quarantine. R263's admission Mated 9/25/21, including personal per	Id be placed in a 14-day they have a negative test upon idance also requires staff to protective equipment (PPE), oves, eye protection and an respirator for residents on the Minimum Data Set (MDS) uded severe cognitive				
	impairment, had a hip fracture and required extensive staff assistance for locomotion. R263 was not on isolation or quarantine for an active infection.					
		Record identified R236 had //20/21, and had not been COVID-19.				
	resident requires tra related to potential exposure for the first and/or an actual po Staff were directed,	ated 9/20/21, included, "The ansmission based precautions pre-admission COVID-19 st 14 days from admission sitive COVID-19 test result." "Follow DROPLET nen caring for this resident."				
	included, "Patient o Encourage patient areas. Wear observ	rder summary dated 9/28/21, n observation until 10/4/21. to wear mask in common vation PPE with close contact. sident at meal times, every				
		istant worksheet, 3 Gamble 4/21, included R263 was to be I 10/4/21.				
	During observation	on 9/27/21, at 1:56 p.m. R263				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 13 of 32

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE COMPLETED (EACH CORRECTIVE ACTION SHOULD BE		NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER WALKER METHODIST HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE							
WALKER METHODIST HEALTH CENTER 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED IN COMPLETED I			00276	B. WING		09/3	30/2021
WALKER METHODIST HEALTH CENTER MINNEAPOLIS, MN 55409 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	WALKER	R METHODIST HEALT	H CENTER				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AFFROMATE DEFICIENCY)		(EACH DEFICIENC)			(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETE DATE
was in the dining room with other residents and was not wearing a mask. Physical therapy aide, (PTA)-A entered the dining room and took R263 to the therapy room and transferred her to an exercise table with no gown or gloves on. PTA-A assisted R263 with table exercises, then assisted up and ambulated R263 in the hallway around several other residents. R263 was never offered a mask to wear and PTA-A never put on a gown or gloves. During observation on 9/28/21, at 8:19 a.m. R263 was at the dining room table with another resident, neither resident wore a face mask for source control and they were not 6 feet apart. When interviewed on 9/28/21 at 8:29 a.m. RN-A stated R263 was on transmission based precautions (TBP) due to being a new admission that was not vaccinated for COVID-19. Further, stated there should be a sign on the door that allows the staff to know what TBP the resident is on and what PPE to use. The door to R236's room did not indicate she was on any sort of precautions. During observation on 9/28/21, at 9:23 a.m. PTA-B took R263 from the dining room into the therapy room and completed leg exercises without wearing a gown or gloves. Further, PTA-B ambulated R263 in the hallway using a walker and holding onto the gait belt while ambulating R263 in close distance of 5 other residents. R263 did not have a mask on throughout the therapy session. Directly after working with R263, PTA-B ween into R500's room and completed exercises with the resident. PTA-B wore the same clothing, mask and eye protection as they did with R263. When interviewed on 9/28/21, at 9:45 a.m. PTA-B	21375	was in the dining rowas not wearing a recommendate (PTA)-A entered the to the therapy room exercise table with assisted R263 with up and ambulated research or gloves. During observation was at the dining rowas at the resident, neither resource control and when interviewed a stated R263 was on precautions (TBP) that was not vaccing stated there should allows the staff to keep on and what PPE to room did not indicate precautions. During observation PTA-B took R263 for the took R263 for the rapy room and continuous without wearing a gambulated R263 in and holding onto the R263 in close distance did not have a mass session. Directly affective went into R500's rowith the resident. Proceedings and the resident. Proceedings are reconsidered to the resident. Proceedings and the resident. Proceedings are reconsidered to the	com with other residents and mask. Physical therapy aide, e dining room and took R263 in and transferred her to an ino gown or gloves on. PTA-A table exercises, then assisted R263 in the hallway around ents. R263 was never offered d PTA-A never put on a gown on 9/28/21, at 8:19 a.m. R263 com table with another sident wore a face mask for they were not 6 feet apart. On 9/28/21, at 8:29 a.m. RN-A in transmission based due to being a new admission lated for COVID-19. Further, if be a sign on the door that know what TBP the resident is to use. The door to R236's ate she was on any sort of on 9/28/21, at 9:23 a.m. from the dining room into the completed leg exercises gown or gloves. Further, PTA-B the hallway using a walker regait belt while ambulating ince of 5 other residents. R263 k on throughout the therapy there working with R263, PTA-B com and completed exercises and completed ex	21375			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 14 of 32

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:			
		00276	B. WING		09/3	0/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	precautions. Further worn a mask while as a gown and glow while working with I During observation R263 was sitting in residents with no magnetic to a sitting in residents with a sign of the resident of the resident was a sitting in resident with a sign on the resident was a sitting in resident with a sign on the resident was a sitting in resident was resident was resident was resident and residents may be gown, gloves, mask RN-B stated, all obstant a TBP sign inside the resident is on. If should know who is to use according to was no other commandepartments excep R236 did not have a door. RN-B confirm vaccinated against	e of R263 being on any type of er, verified R263 should have out of the room and PPE such res should have been worn R263. on 9/28/21, at 10:17 a.m. the TV room with 5 other task on. All residents were part. on 9/28/21, at 11:00 a.m. the stated the therapy staff should in precautions in the room if irector of therapy stated the low who is on precautions by a ts door. on 9/28/21, at 11:10 a.m. fection preventionist (RN)-B admitted who was not fully coinated, was to be placed on tions and full personal int (PPE) was to be worn since have COVID-19, such as a canded the control of the resident and what TBP further, RN-B stated therapy is on precautions and what PPE their treatment plan, There	21375			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 15 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		00276	B. WING		 	C 30/2021
	PROVIDER OR SUPPLIER	H CENTER 3737 BR	ADDRESS, CITY, S RYANT AVENUE APOLIS, MN 55	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From page 15		21375			
	was sitting in the Toother residents. All each other. When interviewed on nursing assistant (Naware R263 was st NA-A stated R263 wear a mask if ask When interviewed ostated they did not	on 9/28/21, at 1:38 p.m. RN-C know why R263 had not been	5 f			
	out of the room tod be quarantined to r	ouraged to wear a mask while ay. RN-C verified R263 should oom and if needed to come be encouraged to wear a				
	licensed practical not made any atten	on 9/28/21, at 1:50 p.m. lurse (LPN)-B stated they had npt to quarantine R263 in her s is a dementia unit."				
	resident infection p indicated the purpo COVID-19 is to gui and to prevent the indicated a residen testing positive for	ng and Surveillance of revention policy dated 8/30/21 use of the surveillance of de appropriate interventions spread of COVID-19. Further, to that doesn't have a history of COVID-19, or is not fully be placed in a private room of the for 14 days.				
	Infection Control Po eye protection, mas be worn for residen	nents for Health Care Workers olicy dated 6/28/21, indicated sks, gowns, and gloves would ats with suspected or COVID-19 by healthcare				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 16 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		SURVEY PLETED
			7 BOILBING.			C
		00276	B. WING			30/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKE	R METHODIST HEALT	H CENTER	ANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	personnel. The IJ which begar 9/29/21, after the far plan which included residents on the aff COVID-19, the faci policy, all residents signage placed on placed, staff were efor education prior of Verification of imple was completed by document review. During an observation nursing assistant Nameals wearing mass was not wearing eyinterviewed NA-K son his eye protection be over his nose. During an observation a.m. NA-J entered protection. During an observation had goggles and was as a possible of the protection of the protecti	in on 9/27/21, was removed on a cility implemented a removal of the following actions: all fected unit were tested for lity updated their observation on quarantine/isolation had door, a yellow wrist band educated and notified of need to working next shift. It is mentation of the removal plan observation, interview and it is in on 9/28/21, at 8:45 a.m. A-K was observed delivering sk under nose his nose and reprotection. When tated he had forgotten to put on and knew his mask should it in nursing on 9/28/21 at 8:52 a resident's room with no eye it ion on 9/28/21, at 8:53 a.m. It is without eye protection and room delivering meals. When tated she forgot to wear her ware she needed them. On 9/28/21, at 8:58 a.m. RN-L who on the tip of her nose not RN-L stated she had a hard orggles closer to her face she would fall when she would	21375			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 17 of 32

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:

00276

(X3) DATE SURVEY COMPLETED

B. WING _____

C **09/30/2021**

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
		3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENT (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 17 on wearing the goggles to protect her	eyes.	21375		
	R61's quarterly MDS dated 7/26/21, in R61 had a BIMS of 14 with intact cog MDS also indicated R61 required exteassistance for toileting and personal houring observation on 9/27/21, at 1:00 entered R61's room, donned gloves, R61's soiled incontinent brief, perform and applied barrier cream to the perint then without removing gloves or performant brief applied a clean incontinent brief the covers over R61, placed the televicontrol on the resident, and pulled the table to R61. Then NA-L removed her performed hand hygiene. When interestated she should have removed her washed her hands between the dirty at tasks.	nition. The ensive hygiene. 9 p.m. NA-L removed hed pericare, neum. NA-L orming hand rief, pulled ision remote bedside gloves and viewed NA-L gloves and			
	During an interview on 9/30/21, at 1:5 director of nursing (DON) stated staff perform hand hygiene when going fro clean during resident cares; this inclu applying cream to a resident's bottom. The DON stated staff should remove wash their hands or use hand sanitize on new gloves before continuing with	should om dirty to ded after and groin. their gloves, er, then put			
	The facility Hand Hygiene policy dated 6/1/19, indicated staff should perform hand hygiene after touching body substances and any potentially contaminated objects, such as dressings, bedpans, basins, clothing, or linen and so forth.				
	SUGGESTED METHOD OF CORRE	CTION: The			

Minnesota Department of Health STATE FORM

WQHW11 If continuation sheet 18 of 32

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
,	o. oo.u.20.10.1		A. BUILDING:		
		00276	B. WING		C 09/30/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU POLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21375	review/revise facility contain all compone program, including trending of all illnes implementation of a COVID-19 transmis appropriate use of I working with sympt are being performe. The DON or design existing or revised pensure the policies results of those aud Assurance Perform to determine complemonitoring. Time Period for Codays.	ursing) or designee should y policies to ensure they ents of an infection control daily cumulative tracking and uses in the facility, immediate droplet precautions to mitigate ssion, and ensure the PPE and prevented from oms of COVID-19 and cares d appropriately and timely. The could educate all staff on policies and perform audits to are being followed. The dits should be taken to Quality ance Improvement committee liance and the need for further trection: Twenty-one (21)	21375		
21610	and Preparation Are Subpart 1. Storage must store all drugs under proper tempe only authorized nur- access to the keys. This MN Requirement by: Based on observation	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have ent is not met as evidenced ion, interview, and record ailed to ensure medications	21610	Correction date on or before 11/10/	2021
	resident (R474) wh storage and labeling to remove expired of	ocured safely for 1 of 20 o was reviewed for medication g. In addition, the facility failed or discontued medications and n refrigerator temperatures in			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 19 of 32

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00276	B. WING		09/3) 0/2021
NAME OF I	PROVIDER OR SUPPLIER		l	STATE, ZIP CODE	1 00/0	0/2021
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	R422, R455, R466, reviewed for medical Findings include: During an observat registered nurse (Rinurse RN-M walked cart to assist another was left unlocked at top of the cart unatt within five feet of the housekeeping stafficant. RN-M was award for roughly 4 m. The medications will medication cart included to the cart fluid recaused by congesting abapentin (anti-expectation cart included to the caused by congesting abapentin (anti-expectation cart included to the caused by congesting abapentin (anti-expectation cart included to the caused by congesting abapentin (anti-expectation cart included to the caused by congesting abapentin (anti-expectation cart included to the caused by congesting abapentin (anti-expectation cart included to the cart included to	ge for 7 of 20 residents (R55, R477, R488 and R499) ation storage. ion on 9/30/21, at 8:09 a.m. N)-M was observed to walked daway from the medication cart nd medications were left un tended. Two residents were e unlocked cart and two walked pasted the medication ay from the medication and inutes. hich had been left on top of the uded: tention (edema) and swelling ve heart failure) pileptic medication used to	21610			
	RN-M stated he left nurse. RN-M furthe medication adminis	on 9/30/21, at 8:18 a.m. If the cart to help another er stated he was educated on extration and storage to not on top of the medication cart				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 20 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		00276	B. WING		I	C 30/2021
	PROVIDER OR SUPPLIER R METHODIST HEALT	H CENTER 3737 E	T ADDRESS, CITY, S BRYANT AVENUE EAPOLIS, MN 55	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21610	or leave the medica stated someone comedications when I During an interview RN-E stated medications and the medications. During an interview assistant director of medications should medication cart or increase in proximity the stated leaving the repeople at risk for act stated her expectated to secure medication way. Facility's policy Medicated, indicated timely administration and to ensure safe	ation cart unlocked. RN-M ould have taken the left unattended. on 9/30/21, at 8:48 a.m. with ations should not be left on ation cart should not be left urse should not walk away at ons unattended. RN-E further a staff member could take on 9/30/21, at 1:00 p.m. the finursing (ADON) stated if never be left on top of the the cart unlocked without the othe cart. ADON further medications out could put ocidental ingestion. ADON tion would be for nursing states and cart before walking dication Storage in The Facilensure accurate, safe, and on of drugs to our residents, storage of supplies. The otted the nurse to carry the cates.	the and er the			
	floor, odd side of ha at 12:12 p.m. a bot found with R55's na and birthdate on it. no date indicating v Registered nurse (I packaging with the	v and observation of the fifth all, medication cart on 9/30/2 tle of saline eye drops was ame, medical record numbe The bottle was half empty w when it was opened. RN)-Q verified the original pharmacy label was not in t N-Q stated he did not know	r, ⁄ith			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 21 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/S	SUPPLIER/CLIA FION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BUILDING:		. .	_
		00276		B. WING			C 30/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WALKE	R METHODIST HEALT	H CENTER		ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21610	Continued From particles when the eye drops did not know when During an interview fifth-floor medication p.m. a bottle of liquit found in the refrige RN-Q stated had p. The lorazepam was 8/11/21. The therm indicated the temperature should belonging to R455, refrigerator, which is not being held at reasonable to the stated she was unsupported by the stated she was unsupported for after it was be used for staff or A box of Tylenol suin the refrigerator was solution package in stored at 35-46 deggood only 30 days. During an interview for the tylenol suin the refrigerator was solution package in stored at 35-46 deggood only 30 days. During an interview third-floor medication, m. ertapenem (and the of 9/10/21, and expiration date of 9/10/21, and 9/10/21, an	s were opened they would experience on room on 9/30 assed away, "a silled by the prometer in the relature was 50 verified the tem know what the dobe. Various in R466 and R47 would expire we frigerator temperature in open date of sure how long to so opened. The any newly admitted in positories was with an expiration of the any newly admitted in open date of sure how long to so opened. The any newly admitted in open date of sure how long to so opened. The any newly admitted in open date of sure how long to so opened. The any newly admitted in open date of sure how long to so opened. The any newly admitted in an	on of the 0/21, at 12:26 a narcotic) was a to R422, whom awhile a go." harmacy on refrigerator degrees perature and correct issulin's 77 were in the rithin 28 days of perature of on of the /30/21, at 12:50 d to detect 7/26/21. RN-R uberculin was solution could nitted residents. Is also observed on date of otein Derivative it was to be reit, and was he solution. On of the 80/21, at 1:15 h an expiration in with an ing to two	21610			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 22 of 32

Minnesota Department of Health

AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С	
		00276	B. WING		09/3	0/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 22	21610			
	Aller-ease, a stock expiration date of 7, managers destroyed did not know the proof of the medication room fifth, fourth, and thir	rigerator temperature logs for as that were observed, (sixth, ad floors) were incomplete.				
	12/7/16, indicated of be immediately rem of according to polic medications that re-	ion Storage policy dated butdated medications were to noved from stock and disposed by. The policy also indicated quired refrigeration were to be 3 degrees Fahrenheit.				
	administrator, direct consulting pharmact policies and procedt medications including temperatures. Nurse the importance of part of the DON or design	THOD OF CORRECTION: The tor of nursing (DON) and sist could review and revise ures for proper storage of ng medication refrigerator ing staff could be educated on roperly storing medications. ee, along with the pharmacist, is on a regular basis to ensure				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21665	MN Rule 4658.1400) Physical Environment	21665			11/10/21
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.				

Minnesota Department of Health

Minnesota Department of Health

AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00276 B. WING		09/3	0/2021		
					1 00/0	0/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 23	21665			
	by: Based on observati review, the facility fa of feeding tube pole and R150) residents Findings include:	ent is not met as evidenced on, interview, and document ailed to ensure the cleanliness es for 2 of 3 residents (R58 s reviewed for tube feeding.		Correction date on or before 11/10)/2021	
		evere cognitive impairment				
	bottle of tube feedir metal pole and forr gastric tube. The m drippings on it and	ion on 9/29/21, at 9:34 a.m. a ng formula was hanging from a mula was infusing into R58's etal pole had dried formula dried formula splatter on the nere was also dried formula se of the pump.				
	at 12:09 p.m. regist R58's room to perfo stated the dried form	ion and interview on 9/29/21, ered nurse (RN)-O entered orm gastric tube cares. RN-O mula on R58's tube feeding uld not be there and was not				
		ual MDS dated 8/26/21, rintact and received a tube				
	at 10:53 a.m. a 150 formula with tubing from a metal pole n drippings of dried fo	ion and interview on 9/28/21, 0 ml bottle of tube feeding attached, was found hanging ext to R150's bed. Multiple ormula ran down the pole and mula was on the base of the				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 24 of 32

Minnesota Department of Health

AND DIAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		00276	B. WING		09/3) 0/2021
	PROVIDER OR SUPPLIER	H CENTER 3737 BRY	DRESS, CITY, S ANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21665	pole. Also observed formula across the pump. RN-P acknown the equipment and should have been of any staff member of equipment. During an observation tube feeding pole in feeding formula on and pump. During an observation the same dried form was observed on the and pump in R150's director of nursing (splatter from tube feeding to dried and inistering the tubes of the analyse of the same dried form the same dried of the same dried form the same dried form the same dried in the same dried form the same dried in the same dried form the same dried form the same dried in the same dried form the same dri	If were drippings of dried face of the tube feeding wledged the dried formula on stated it was not sanitary and cleaned. RN-P further stated ould have cleaned the fon on 9/29/21, at 7:35 a.m. a R150's room had dried tube the pole, base, electrical cord, from on 9/29/21, at 2:30 p.m. and drippings and splatter the pole, base, electrical cord, as room. on 9/30/21, at 1:54 p.m. the DON) stated drippings and eleding formula should have the drippings and should not y for multiple days. The DON formula on equipment was	21665			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND DIAN OF CODDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:) DATE SURVEY COMPLETED		
		00276		B. WING			C 30/2021
	PROVIDER OR SUPPLIER	TH OFNITED		DRESS, CITY,	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	MINNEAP	OLIS, MN 5	5409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ige 25		21805			
21805	MN St. Statute 144 Residents of HC Fa		ients &	21805			11/10/21
	Subd. 5. Courteouresidents have the courtesy and respeemployees of or pehealth care facility.	right to be treated ct for their individ	d with luality by				
	This MN Requirements by: Based on observation review, the facility for treatment for 2 of 4 reviewed, who had staff treatment.	ion, interview, an ailed to ensure d residents (R59 a	d document ignified and R47)		Correction date on or before 11/10	0/2021	
	Findings include:						
	R59's quarterly Min 7/21/21, included, of of heart failure and from staff for ambu	cognitively intact, required extensi	a diagnosis ve assistance				
	When interviewed of stated she felt, "inviroom. R59 stated the knocking and say, soon as the staff are the room without as else.	isible," when staf the staff enter the 'are you done?" I e finished, they c	f were in her e room without R59 stated as puickly leave				
	During an observat nursing assistant (N R59 yelled out, "not room and again R5 later." NA-G walked bag, and walked ou her. At 1:37 p.m. R	NA)-G knocked o t now." NA-G wal 9 stated, "please d past R59, remo ut the door, not ac	n the door, ked into the come back ved the trash cknowledging				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 26 of 32

Minnesota Department of Health

AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		С	
		00276	B. WING		1	0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	NA-G know she wa and then lay down. on R59's door and could grant her per call light is on," as s R59 told NA-G, "I was not respond to her and walked out of the walked back into R the toilet. NA-G left closing the door or R59 could be seen toilet. NA-G then wasked R59, "done you stayed in the room singing in a foreign she was finished. Not be and left the room conversation, or as comfortable or if show the interviewed of the resident's room. When interviewed of the resident's room. When interviewed of the resident's room with the resident with the re	At 1:44 p.m. NA-G knocked entered the room before R59's mission. NA-G only said, "Your she turned the call light off. and to go to bed." NA-G did request, but turned around he room. At 1:52 p.m. NA-G 59's room and assisted R59 to R59 on the toilet without pulling the privacy curtain. from the hallway sitting on the alked back into the room and a yet?" R59 stated, "no." NA-G without speaking to R59, language until R59 indicated IA-G then assisted R59 to her om without making any king R59 if she was be needed anything else. Sen 9/30/21, at 3:15 p.m. and six ask what they needed, and anything else before they left	21805			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00276	B. WING		I	C 30/2021
	PROVIDER OR SUPPLIER	H CENTER 3737 BRY	DRESS, CITY, S ANT AVENUI OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 27	21805			
	a vulnerable adult v depressive disorder bi-polar with a prefe Interventions includ feelings and providi R47. R47's Order Summ indicated blood glud The report also indi aspart solution on a	red 7/14/21, indicated R47 was with a history of major related to anxiety and erence to isolation. ded allowing R47 to expressing a safe environment for ary Report dated 9/30/21, cose monitoring before meals. cated R47 received insuling scale by injection, with its of NovoLog (insulin) by				
	stood next to R47, and asked him loud. There were 6 other stated, "no." RN-N to check his blood s RN-N wheeled R47 and faced him towa other residents and checked R47's bloc expose his abdome entire dining room, interviewed, RN-N s the dining room, "it When interviewed of stated he did not lik in the hallway where by. R47 stated he was taked	on 9/30/21, at 8:21 a.m. RN-N who was in the dining room lly if he was having pain. residents in the area. R47 explained to R47 she needed sugar and give him his insulin. 's wheel chair to the hallway and the dining room where staff were present. RN-N od sugar and lifted his shirt to en, still within eyesight of the and injected the insulin. When stated they give medications in is how it's always done." on 9/30/21, at 5:56 p.m. R47 re receiving his insulin injection e other people were walking would have preferred to have it room where it was private. It				
		on 9/30/21, at 1:54 p.m. the				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 28 of 32

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		С	
		00276	B. WING			0/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENUI OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
		·	.,,,	DEFICIENCY)		
21805	Continued From pa	ge 28	21805			
	when administering injections. The DON further stated the medication cart by the dining room was not a private setting because other people could walk by and see the injection being administered.					
	8/1/19, indicated re dignity and respect enhancing resident indicated staff were which protected resinformation includin outside the hearing the public. The polic promote and protect	of Life-Dignity policy, revised sidents were to be treated with at all times by maintaining and s' self-esteem. The policy to maintain an environment sident's confidential, clinical g conducting conversations range of other residents and cy also indicated staff should at resident privacy, including ag assistance with cares and				
	The director of nurs review/revise policies staff on those policies could conduct audit residents are treater	THOD OF CORRECTION: sing and/or designee could es on dignity and educate all les. The DON and/or designee is of resident cares to ensure ed with dignity. R CORRECTION: Twenty one				
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			11/10/21
	residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve their sical and mental functioning. where the service is not blic or private resources.				

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 29 of 32

Minnesota Department of Health

AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00276		B. WING		C 09/30/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
WALKER	R METHODIST HEALT	H CENTER	ANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 29	21810			
	by: Based on observati review, the facility for reach for 1 of 3 res were dependent up	ent is not met as evidenced on, interview and document ailed to place a call light within idents (R150) reviewed who on staff for assistance and call light for assistance.		Correction date on or before 11/1	0/2021	
	8/26/21, included, of cord injury with fund upper extremities a	mum Data Set (MDS) dated cognitively intact, had a spinal ctional impairment of both nd one lower extremity and ent upon staff for bed mobility, and toileting.				
	8/26/21, indicated, due to contractures R150 was at risk fo maintaining balance transfers and had let The CAA further inclimitation in range of	Assessment (CAA) dated complications with mobility and the CAA also indicated a refalls and had difficulty ewhile sitting and during cass of arm or leg movement. Dicated R150 had functional of motion and an inability to feel daily living (ADLs) without cee.				
	was a vulnerable ac providing a safe en plan indicated R150 and was unable to Interventions include needs. The care pla	ated 9/10/21, indicated R150 dult. Interventions included vironment for R150. The care 0 had a communication deficit press the call light well. led staff anticipating R150's an also indicated R150 was at entions included ensuring the reach.				

Minnesota Department of Health

09/30/2021

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

00276 B. WING ____

NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
WALKER	METHODIST HEALTH CENTER		ANT AVENU OLIS, MN 5		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 30		21810		
	During an observation and interview on 9 at 6:03 p.m. R150 was in bed wearing or and no covers. R150 stated she was colneeded a boost in bed. R150 was contrallimited movement in all extremities. R150 able to move her right hand slightly to acmetal, triangle call light if it was attached sheet within her reach; however, the call hanging off the right side of the bed and was unable to activate it or see it.	nly a brief d and acted with 0 was stivate her I to the light was			
	During an observation on 9/28/21, at 11: R150's call light was turned around with activation button facing away from R150 was unable to activate her call button. At a.m. registered nurse (RN)-P was notifie R150's call light.	the . R150 t 11:05			
	During an observation on 9/29/21, at 7:3 R150 activated the call light on her bed. a.m. nursing assistant (NA)-N entered R room to assist R150. R150 requested to boosted in bed. NA-N left briefly and retundation. NA-N and NA-M boosted R150 in attached the call light to the bed with the activation button facing away from R150 and NA-M left R150's room. R150 was unactivate her call button.	At 7:35 150's be urned with bed then			
	The facility Call Light policy revised 6/28/indicated all staff members were to ensure call light was within easy reach for a resi when they are in bed. The policy further a call light was not to be taken away from resident.	re the dent indicated			
	SUGGESTED METHODS OF CORRECT The director of nursing (DON) or designed				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00276	B. WING		l l	C 30/2021
	PROVIDER OR SUPPLIER	H CENTER 3737 BRY	ODRESS, CITY, S YANT AVENU POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21810	develop, review, an procedures to ensu lights within reach. educate all approprious designee could devensure ongoing cor results to the quality	ge 31 d /or revise policies and re all residents have their call The DON or designee could iate staff. The DON or relop monitoring systems to impliance and report those y assurance committee. R CORRECTION: Twenty-one	21810			

Minnesota Department of Health

STATE FORM 6899 WQHW11 If continuation sheet 32 of 32