DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing

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

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

Kamala Fiske-Downing
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	R-C 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments On 11/15/21 through 11/16/21, an onsite revisit was conducted to determine compliance with CMS Appendix Z Emergency Preparedness Requirements cited during a standard recertification survey exited on 9/30/21. The facility is now IN compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS On 11/15/21 through 11/16/21, an onsite revisit was conducted to follow up on deficiencies related to a standard recertification survey exited 9/30/21. The facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was also reviewed: H5055306C (MN76946) was found to be CORRECTED. The following tags were recited: F558, F686, and F761 and were found NOT be corrected and remain OUT OF COMPLIANCE. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 558} SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	{F 558}		11/23/21

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

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.

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{F 558}	Continued From page 1 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would 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) who were dependent upon staff for assistance. 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 R150 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 identified 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 dated 9/10/21, indicated R150 was a vulnerable adult. Interventions included providing a safe environment for R150. The care plan indicated R150 had a communication deficit and was unable to press the call light well. Interventions included staff anticipating R150's	{F 558}	Call light placement education was completed on or prior to 11/10/2021 was reviewed and determined to be current and sufficient. Randomized audits, initiated on or before 11/10/21 will remain in effect. Focused call light placement audits will be performed at least daily for a minimum of 14 days, beginning on or before 11/23/2021. Focused audits will include resident R150 as well as other residents with non-standard call lights and those previously identified with ongoing concerns related to call lights from randomized audits. Results of both randomized and Focused audits will be reported to QAPI for review and recommendations to maintain ongoing compliance. The Administrator or designee will be responsible for ongoing compliance.	

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{F 558}	Continued From page 2	{F 558}		

needs. The care plan also indicated R150 was at risk for falls. Interventions included ensuring the call light was within reach.

During a continuous observation and interview on 11/15/21, from 11:15 a.m. to 1:17 p.m., R150 was observed to be reclined in bed with a metal tent-shaped call light attached to the sheet with one clip, on R150's right side near R150's right hand, however, the activation button, which was only on one side, was facing away from R150; therefore, R150 was unable to activate the call light for assistance. R150 stated when registered nurse (RN)-A gave R150 her morning medication at approximately 10:00 a.m. she had asked RN-A to boost her up in bed. R150 stated RN-A told R150 he would get R150's aid to assist her. R150 stated no staff had come back to reposition her. R150 stated she often had to yell because her call light wasn't positioned correctly. R150 was unable to see the call light, or turn it around due to contractures and paralysis. At 12:13 p.m., R150 had a wet, productive cough and stated she would like some water. R150 again attempted to activate her call light but was unable to because the activation button was facing away from R150. At 1:17 p.m. RN-A was located to assist R150.

During an interview on 11/15/21, at 1:19 p.m. with RN-A identified he had placed the call light close to R150 when he gave R150 her medications that morning. RN-A stated he did not realize the call light activation button was turned around the wrong way causing R150 not to be able to call for assistance.

Observation on 11/16/21, at 11:41 a.m. R150 was reclined in bed with her metal tent-shaped call light pinned to the sheet by her right hand with

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{F 558}	Continued From page 3 one pin and the activation button was facing away from R150. R150 was unable to activate the call light and requested an aid so she could order lunch. Observation and interview on 11/16/21, at 11:49 a.m. with nursing assistant (NA)-A in R150's room identified NA-A confirmed R150's call light was facing the wrong way and R150 would not be able to call for help. During an interview on 11/16/21, at 11:55 a.m. with NA-B who entered R150's room and stated R150's call light needed to be turned around with the activation button facing her, otherwise R150 would not be able to call for assistance. During an interview on 11/16/21, at 12:31 p.m. with the assistant director of nursing (ADON) stated all residents should have call lights within their reach whenever they were in their room and needed assistance. The ADON verified R150 was not included in the facility plan of correction (POC) call light accessibility audits and confirmed that staff were not educated on how different types of call lights worked. The facility Call Light policy revised 6/28/12, indicated all staff members were to ensure the call light was within easy reach for a resident when they are in bed. The policy further indicated a call light was not to be taken away from a resident. There was no indication the policy had been reviewed or revised per the plan of correction.	{F 558}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	{F 686}		11/23/21

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{F 686}	Continued From page 4 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement identified interventions for pressure relieving devices and/or provide timely repositioning for 2 of 3 residents (R58 and R150) reviewed for pressure ulcers. Findings include: R58's quarterly Minimum Data Set (MDS) dated 7/27/21, included severe cognitive impairment with diagnoses including, diabetes, dementia and a stoke with hemiplegia/paresis (weakness or paralysis on one side). R58 required extensive staff assistance with bed mobility, hygiene and dressing and did not refuse cares. R58 was at risk for pressure ulcers. R58's care plan dated 7/28/21, indicated R58 had an activities of daily living (ADL) deficit. Interventions included to assist R58 into his wheelchair after breakfast and back into bed before lunch. The care plan indicated R58 was to have Prevalon boots (special boots that off-load	{F 686}	Repositioning and Pressure Ulcer Prevention education completed on or prior to 11/10/2021 was reviewed and determined to be current and sufficient. Randomized audits, initiated on or before 11/10/21 will remain in effect. Focused repositioning and pressure ulcer prevention audits will be at least twice weekly for 14 days, beginning on or before 11/23/2021. Focused audits will include residents R58 and R150 as well as other residents with pressure relieving devices and treatments who are at high risk for pressure ulcers. Results of both randomized and Focused audits will be reported to QAPI for review and monitoring ongoing compliance. The Director of Nursing or designee will be responsible for ongoing compliance.	

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{F 686}	Continued From page 5	{F 686}		

the heels to prevent pressure on them) on both feet. The care plan also indicated to turn/reposition R58 every two to three hours and heel lift boots should have been applied at all times. The care plan indicated R58's brief was to be checked and changed after breakfast and before lunch. The care plan further indicated R58 had a potential for pressure ulcer development. Interventions included to follow facility protocols for the prevention of skin breakdown, to encourage small, frequent position changes, and to administer all treatments as ordered.

R58's Kardex (nurse aide worksheet) dated 9/16/21, indicated R58 required a total assist for bed mobility and should have been repositioned every 2-3 hours with boots applied to R58's feet.

R58's Order Summary dated 1/3/20, indicated R58 should have had Prevalon boots on both feet, every shift, for wound prevention.

R58's Provider Progress Note dated 7/15/21, indicated R58 was lying in bed, not wearing 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 extremities.

During an observation and interview on 11/15/21, at 1:32 p.m. R58 was awake and lying supine in bed. R58's heels were not floated and the Prevalon boots were on a recliner chair across the room. R58 stated the staff would put the boots on if he asked them to.

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{F 686}	Continued From page 6	{F 686}		

During an observation on 11/16/21, at 11:39 a.m. R58 was supine in bed. R58's heels were not floated and the Prevalon boots were in a chair across the room.

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 dated 3/9/21, indicated R150 was on scheduled pain medication therapy and non-pharmacological interventions related to left knee contracture, shoulder pain, and multiple healing fractures. Interventions included repositioning R150. The care plan also indicated R150 had a history of respiratory infection related to history of COVID 19. Interventions included to change R150's position at least every 2 hours, especially if in bed. The care plan also indicated R150 had a potential for skin impairment due to decreased physical movement, tube feeding, incontinence, malnutrition, and contractures of all extremities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	R-C 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 7	{F 686}		

R150's Physician Orders dated 8/3/19, indicated to turn and reposition R150 every 2 hours off of bony prominence's.

During a continuous observation and interview on 11/15/21, from 11:15 a.m. to 1:17 a.m. R150 was reclined in bed. R150 stated she asked registered nurse (RN)-A to boost her up in bed when RN-A brought R150 her morning medications at 10:00 a.m. RN-A told R150 he would get the nursing assistant (NA) to help R150, but no one had come back to R150's room since. R150's metal triangle-call light was placed on R150's bed attached to the sheet by one clip instead of two, with the activation button facing away from, and out of R150's reach. R150 was able to touch the side of the call light facing her, however, due to immobility, R150 was unable to see the call light and was therefore, unaware she was not activating it to call for assistance. R150 stated she often had to yell for help because her call light doesn't work. At 1:17 p.m. RN-A was located to assist R150.

During an interview on 11/15/21, at 1:19 p.m. RN-A stated R150 should have been repositioned every two hours and that he had not been in R150's room since he gave R150 her medications around 9:30 a.m.

During an interview on 11/16/21, at 12:31 p.m. with the assistant director of nursing (ADON) stated staff should be applying pressure relieving devices according to the physician orders and/or care plan. The ADON stated if a resident continuously refused to have pressure relieving devices applied, the interdisciplinary team (IDT) should have been notified and alternative treatments should have been considered. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 686}	Continued From page 8 ADON stated resident refusals would not necessarily be documented but the resident's care plan would reflect any new interventions. The ADON stated if a resident refused to have their heels floated as an alternative to Prevalon boots, the staff should have continued to re-approach the resident and education should have been provided to the resident and their family regarding the risks and benefits of pressure relieving measures. The ADON also verified that R58 was not included in the facility plan of correction (POC) pressure relieving devices audit. The ADON further stated both residents should have been repositioned every two hours to avoid skin breakdown and the development of pressure ulcers. The facility Skin and Wound Care policy revised 8/1/19, indicated staff were to ensure residents admitted to the facility received care to prevent pressure ulcers from developing. The policy also indicated physician orders and/or pressure relieving nursing interventions were to be implemented when a compromised skin integrity was observed. There was no indication the policy had been reviewed or revised according to the plan of correction.	{F 686}		
{F 761} SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	{F 761}		11/23/21

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{F 761}	Continued From page 9 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure expired and/or discontinued narcotic medications were disposed of in a timely manner from 1 of 4 medication storage rooms observed for medication storage. Findings include: During an observation and interview on 11/16/21, at 3:08 p.m. a bottle of liquid lorazepam (a narcotic) that was filled by the pharmacy on 1/7/20, was found in the sixth-floor medication refrigerator. Registered nurse (RN)-B verified the Lorazepam was last used by R90 over a year ago and should have been disposed of. R90's previous physician orders dated 1/7/20, indicated R90 had received 0.25 milliliters (ml) of Lorazepam solution 2 milligrams (mg) per ml twice per day at that time. The order for	{F 761}	A comprehensive review of all medication carts, medication rooms and medication refrigerators will be completed on or before 11/23/2021 and all medications not in use by active residents, expired medications, or improperly stored and dated medications were removed and will be destroyed according to facility policy. A randomized weekly audit will be performed across all units on a weekly basis. Audits will be reviewed by the Director of Nursing or designee. Results of the audits will be reported to QAPI for review and further recommendations The Director of Nursing or designee will be responsible for ongoing compliance.	

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{F 761}	Continued From page 10 Lorazepam was discontinued on 1/14/20. R90's Medication Administration Record (MAR) indicated R90 had not received Lorazepam solution after 1/14/20. During an interview on 11/16/21, at 12:35 p.m. with the assistant director of nursing (ADON) stated narcotic medications that had been discontinued over a year ago should have been destroyed to avoid the risk of diversion and confusion. The ADON verified the sixth-floor medication room refrigerator was not included in the facility plan of correction (POC) medication storage audit. The facility Medication Storage policy dated 12/7/16, indicated outdated medications were to be immediately removed from stock and disposed of according to policy. There was no indication the policy had been reviewed and/or revised per the plan of correction.	{F 761}		

DEPARTMENT OF HEALTH

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

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

Kamala Fiske-Downing
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

Enclosure

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

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

Kamala Fiske-Downing
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/27/21, to 9/30/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency	E 037		11/10/21

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

Electronically Signed | 11/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HEALTH CENTER	**3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409**

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E 037	Continued From page 1	E 037		

procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency

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E 037	Continued From page 2	E 037		

preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at

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E 037	Continued From page 3 least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff,	E 037		

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E 037	Continued From page 4 individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide staff emergency preparedness training at least annually which was based on the facility emergency preparedness plan (EP) for 3 of 3 staff members (RN-D, RN-S and NA-P) reviewed. This had the potential to affect all 217 residents, as well as staff, volunteers and visitors at the facility. Findings include: On 09/30/21, at 4:13 p.m. the EP program was reviewed with the administrator. The	E 037	An audit was conducted for all active staff related to both initial emergency preparedness training and annual training. Any active staff found to be out of compliance will complete necessary emergency preparedness training on or before 11/10/2021 or they will be removed from the schedule until training is complete. Audits will be conducted monthly for a minimum of 6 months to monitor and	

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E 037	Continued From page 5 administrator indicated the facility did not have evidence of EP training for the staff for entire calendar year of 2020, nor in 2021. The administrator indicated training personnel change during 2020 resulted in EP training information as not available to them. The administrator provided employee transcripts which showed registered nurse (RN)-D had EP training last 1/31/19, RN-S on 12/16/19 and nursing assistant (NA)-P on 12/20/19. The facilities Emergency Preparedness Plan dated 1/1/20, identified they would provide training to staff upon hire and annually.	E 037	maintain compliance. Results will be reported to QAPI for further evaluation and recommendations. The Administrator or designee will be responsible for ongoing compliance.	
F 000	INITIAL COMMENTS On 9/27/21 - 9/30/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5055303C (MN58217) (MN58155), H5055298C (MN66507), H5505305C (MN52293), H5055300C (MN63946), H5055302C (MN62631), H5055294C (MN52812), H5055293C (MN54624), H5055296C (MN56183), H5055295C (MN57004), H5055304C (MN59811), H5055297C (MN64144), H5055297C (MN64286), H5055301C (MN67221).	F 000		

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F 000	Continued From page 6 The following complaint was SUBSTANTIATED with deficiency cited at F580: H5055306C (MN76946). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		11/10/21

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F 550	Continued From page 7 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignified treatment for 2 of 4 residents (R59 and R47) reviewed, who had reported concerns related to staff treatment. Findings include: R59's quarterly Minimum Data Set (MDS) dated 7/21/21, included, cognitively intact, a diagnosis of heart failure and required extensive assistance from staff for ambulation and transfers. When interviewed on 9/27/21, at 1:11 p.m. R59 stated she felt, "invisible," when staff were in her room. R59 stated the staff enter the room without	F 550	R59 & R47 received the care and services to ensure privacy and dignity. Their care plans have been reviewed and updated as needed. Policies and procedures were reviewed and remain appropriate Nursing staff will be educated on ensuring resident privacy, knocking on doors and awaiting response before entering, greeting and engaging with residents when providing assistance and cares. Audits for monitoring protection of resident dignity and privacy will be	

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F 550	Continued From page 8 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 left R59 on the toilet without closing the door or pulling the privacy curtain. R59 could be seen from the hallway sitting on 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 ask if they needed anything else before they left the resident's room.	F 550	conducted daily for 14 days then weekly for a minimum of 6 weeks. Licensed nursing staff have also been educated on protecting resident□s confidential, clinical information and privacy with medication administration. Monitoring for compliance will be ensured through random weekly observational audits for a minimum of 8 weeks. Facility QAPI Committee will review audit results and make further recommendations. Director of Nursing or designee will be responsible for ensuring compliance.	

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When interviewed on 9/30/21, at 4:57 p.m. the director of nursing (DON) stated all staff are to ensure all the resident's needs are met before they leave the room. DON stated all staff receive dignity training when they start working at the facility.

R47's quarterly MDS dated 7/13/21, included, cognitively intact with a diagnosis of diabetes and received insulin injections daily. R47 required extensive staff assistance with dressing and transfers.

R47's care plan dated 7/14/21, indicated R47 was a vulnerable adult with a history of major depressive disorder related to anxiety and bi-polar with a preference to isolation. Interventions included allowing R47 to express feelings and providing a safe environment for R47.

R47's Order Summary Report dated 9/30/21, indicated blood glucose monitoring before meals. The report also indicated R47 received insulin aspart solution on a sliding scale by injection, with meals, and four units of NovoLog (insulin) by pen-injector, three times per day.

During observation on 9/30/21, at 8:21 a.m. RN-N stood next to R47, who was in the dining room and asked him loudly if he was having pain. There were 6 other residents in the area. R47 stated, "no." RN-N explained to R47 she needed to check his blood sugar and give him his insulin. RN-N wheeled R47's wheel chair to the hallway and faced him toward the dining room where other residents and staff were present. RN-N checked R47's blood sugar and lifted his shirt to

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F 550	Continued From page 10 expose his abdomen, still within eyesight of the entire dining room, and injected the insulin. When interviewed, RN-N stated they give medications in the dining room, "it is how it's always done." When interviewed on 9/30/21, at 5:56 p.m. R47 stated he did not like receiving his insulin injection in the hallway where other people were walking by. R47 stated he would have preferred to have it administered in his room where it was private. It was embarrassing. When interviewed on 9/30/21, at 1:54 p.m. the DON stated staff should provide residents privacy 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. The facility Quality of Life-Dignity policy, revised 8/1/19, indicated residents were to be treated with dignity and respect at all times by maintaining and enhancing residents' self-esteem. The policy indicated staff were to maintain an environment which protected resident's confidential, clinical information including conducting conversations outside the hearing range of other residents and the public. The policy also indicated staff should promote and protect resident privacy, including bodily privacy, during assistance with cares and treatments.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would	F 558		11/10/21

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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: 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 dated 9/10/21, indicated R150 was a vulnerable adult. Interventions included providing a safe environment for R150. The care plan indicated R150 had a communication 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 risk for falls. Interventions included ensuring the call light was within reach.	F 558	R150□s care plan reviewed and revised as needed. Policies and Procedures were reviewed and remain appropriate. Nursing staff will be educated to ensure call lights are within resident reach at all 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 audit results and make further recommendations. Director of Nursing or designee will be responsible for ensuring compliance	

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F 558	Continued From page 12 During an observation and interview on 9/27/21, at 6:03 p.m. R150 was in bed wearing only a brief and no covers. R150 stated she was cold and needed a boost in bed. R150 was contracted with limited movement in all extremities. R150 was able to move her right hand slightly to activate her metal, triangle call light if it was attached to the sheet within her reach; however, the call light was hanging off the right side of the bed and R150 was unable to activate it or see it. During an observation on 9/28/21, at 11:01 a.m. R150's call light was turned around with the activation button facing away from R150. R150 was unable to activate her call button. At 11:05 a.m. registered nurse (RN)-P was notified about R150's call light. During an observation on 9/29/21, at 7:34 a.m. R150 activated the call light on her bed. At 7:35 a.m. nursing assistant (NA)-N entered R150's room to assist R150. R150 requested to be boosted in bed. NA-N left briefly and returned with NA-M. NA-N and NA-M boosted R150 in bed then attached the call light to the bed with the activation button facing away from R150. NA-N and NA-M left R150's room. R150 was unable to activate her call button. The facility Call Light policy revised 6/28/12, indicated all staff members were to ensure the call light was within easy reach for a resident when they are in bed. The policy further indicated a call light was not to be taken away from a resident.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		11/10/21

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F 580	Continued From page 13 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 14 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to notify the provider and resident representative when a resident experienced nausea, vomiting, hallucinations, and confusion, for 1 of 1 residents (R197) reviewed for change in condition. Findings include: R197's annual Minimum Data Set (MDS) dated 9/3/21, included, cognitively intact and required extensive assistance for most activities of daily living (ADL's). R197 had a discharge MDS dated 9/6/21, which indicated an unplanned discharge to the hospital. R197 had a return to facility MDS winch indicated a return date of 9/10/21. R197 had another discharge MDS dated 9/17/21, which indicated another unplanned discharge to the hospital. R197's admission record dated 9/30/21, indicated R197 had diagnoses including heart, lung and kidney disease, Parkinson's disease and diabetes. R197's care plan dated 9/10/21, indicated R197 was at risk for a fluid deficit related to dementia.	F 580	R197 had discharged prior to time of survey Policy and procedure for change of condition notification reviewed and remains appropriate. Licensed staff have been educated on identification of change of condition, proper notification of family and provider with proper documentation. Monitoring to ensure compliance will be ensured through random weekly chart audits of residents experiencing a change of condition to ensure proper notification and documentation has occurred. Audits will be conducted for a minimum of 8 weeks. Facility QAPI Committee will review audit results and make further recommendations. The Director of Nursing or designee will be responsible for maintaining ongoing compliance.	

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Staff were directed to administer R197's medications as ordered. Further, staff were to monitor R197's vital signs, as ordered, and notify the physician of significant abnormalities.

R197's progress note (PN) dated 9/10/21, at 3:10 p.m. indicated R197 was not feeling well and was not specific except for a poor appetite.

R197's PN dated 9/11/21, at 7:38 a.m. indicated R197 was readmitted to the facility after hospitalization for diverticulitis and pneumonia.

R197's therapy PN dated 9/11/21, at 10:33 a.m. indicated R197 refused therapy because she was too tired to get out of bed.

R197's occupational therapy (OT) PN dated 9/11/21, at 4:03 p.m. indicated OT attempted to see R197 and R197 declined stated she was too fatigued to participate.

R197's physical therapy (PT) PN dated 9/13/21, at 11:54 p.m. indicated R197 reported she was too fatigued, had nausea and vomiting, and abdominal pain. R197's PT PN further indicated nursing was notified.

R197's OT PN dated 9/13/21, at 3:27 p.m. indicated OT reattempted to see R197 for an evaluation with physical therapy (PT) present. PN further indicated R197 was confused and stated she was not feeling well, was stating she'll try tomorrow and nursing was informed.

R197's nurse practitioner (NP) PN dated 9/13/21, R197 had recently finished levofloxacin and Flagyl for pneumonia and diverticulitis. R197 had diminished lung sounds using supplemental

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oxygen with noted expiratory wheezes. PN further indicated R 197 skin was pale in color, pain and tenderness was reported in left quadrant and lower right mid quadrant. PN indicated with a cough and congestion. PN further indicated a plan to recheck a basic metabolic panel (BMP) and complete blood count (CBC) on 9/16/21. There was no evidence R197's representative was contacted.

R197's PN dated 9/14/21 at 2:18 p.m. R197 complained of stomach pain and required pain medications. R197 ate 20% of her breakfast. There was no indication the provider or resident representative was contacted.

R197's PN dated 9/16/21, at 11:11 a.m. indicated therapy reported resident was confused when therapy attempted to work with R197. R197's PN further indicated to let nurse practitioner (NP)-A know confusion. PN indicated writer observed R197 talking out loud to people R197 only saw in room (hallucination). PN indicated R197's was talking to FM-A and to R197 deceased mother. PN further indicated R197 saw three women she did not know were in her room all day, all of them dressed in flowing white gowns. R197 ate a few bites, complained of left side lower abdominal pain, and had a cough with clear phlegm. Blood pressure was 100/48. PN further indicated a voice message would be left for NP-A. There was no indication R197's representative had been notified or if the NP had actually been notified.

R197's PN dated 9/16/21, at 2:59 p.m. indicated R197 was alert and oriented with some confusion and ate bites of breakfast and lunch. R197's PN indicated they would continue to monitor. There was no indication R197's representative had been

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notified or if the NP had actually been notified.

R197's PN dated 9/16/21, at 3:08 p.m. indicated R197 was found to have a skin tear on her left arm measuring one centimeter (cm) by 0.5 cm. PN further indicated a voice message would be left for NP-A.

R197's PN dated 9/16/21, at 3:35 p.m. indicated R197 refused therapy. PN further indicated nursing reported to therapy she had refused to get out of bed.

R197's PN dated 9/17/21, at 2:02 p.m. indicated FM-A was notified by social worker (SW) around 12:30 p.m. on R197's updated change in status of R197 experienced lethargy, ate less at meals, and required assistance with eating. PN further indicated, FM-A demanded R197 be sent to the hospital and FM-A called 911.

R197's PN dated 9/17/21, at 12:55 p.m nursing PN indicated FM-A called 911 and insisted that resident be seen in ER due to increased lethargy and sleepiness. Paramedics transported R197 at 2:00 p.m. The NP was informed of transfer.

R197's Lab Results Report dated 9/17/21, indicated an elevated white blood count, which may indicate infection and a critically low potassium level, which can be life threatening, an elevated calcium level and low chloride level.

R197's Hospital Discharge Summary dated 9/24/21, indicated R197 had been admitted with the diagnosis of failure to thrive secondary to clostridium difficile colitis and urinary tract infection (UTI) . R197 Hospital Discharge Summary further indicated R197 was admitted

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from a skilled nursing facility with increase in weakness and lethargy.

During an interview on 9/30/21, at 12:19 p.m. PT-A stated when she went to see R197 in her room prior to her hospitalization, and R197 stated she was too tired and required PT-A to assist her with taking sips of water because she was weak. PT-A stated they had notified the nursing staff.

During an interview on 9/30/21, at 12:35 p.m. SW-B stated she notified FM-A on 9/17/21, around 11:30 a.m. of the concern with R197 health. SW-B was not aware nursing had not kept R197's representative updated.

During an interview on 9/30/21, at 1:00 p.m. the assistant director of nursing (ADON) stated NP-A was notified of concern on 9/17/21. NP saw resident on 9/13/21 for a Medicare visit after a recent hospitalization. ADON stated FM-A called 911 due to R197 due to increased lethargy and sleepiness. ADON further stated the progress notes indicated NP-A, by a voice message about a skin tear. ADON stated she did not see communication to the provider informing NP-A of R197's symptoms of confusion, change of appetite, stomach pain, or hallucinations. ADON stated, "it would be my expectation for the staff to notify the NP by the next day, within 24 hours." ADON stated FM-A should have been notified each day there was concern especially on 9/14/21, and after. The nursing staff were expected to follow R197's physician orders and plan of care and update the physician and family timely.

During an interview on 9/30/21, at 1:30 p.m. NP-A stated nursing staff left a voice message on

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R197's skin tear on her arm, but no other notifications regarding R197 who had nausea, vomiting, confusion, and hallucinations. NP-A stated she saw R197 just after the FM-A called 911 due to her concerns in R197 health. NP-A stated her expectation for staff would call the provider with any concerns with a change of condition as soon as possible.

During an interview on 9/30/21, at 2:01 p.m. family member (FM)-A stated she contacted 911 after she received a phone call on 9/17/21, from the SW stating R197 had trouble eating and was lethargic. FM-A stated R197 had just returned to the facility from the hospital due to pneumonia and diverticulitis. FM-A further stated she contacted 911 because of the concerns with her mom not eating and lethargic. FM-A stated R197 was admitted to the hospital on 9/17/21, with UTI and her potassium was low, and C. difficile infection. FM-A stated she was not notified of anything that had occurred from 9/10/21, when she returned to the facility until 9/17/21, when the social worker called.

During an interview on 9/31/21 at 11:00 a.m. OT-A stated she attempted to see R197 a few times for an OT evaluation. R197 declined twice stating stating she did not feel well and was too fatigued to participate in therapies. OT-A stated they had notified nursing staff each time.

The facility's policy Change in Resident Condition dated 5/23/12, indicated in the event a resident is not able to understand information due to impaired cognition the designated resident representative will be informed. The facility's policy further indicated to include functional status, medical care, nursing care, and

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F 580	Continued From page 20 rehabilitation. The facility's directed staff to notify physicians of a change in condition per facility policy. Staff were directed to notify responsible parties of any significant and/or acute change in condition as soon as possible and as indicated by seriousness of condition, and further document notification in resident's chart. The facility's policy directed stat to notify physician of specific signs, symptoms, and laboratory values suggestive of acute illness needing immediate assessment would be reported by licensed staff.	F 580		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to implement pressure injury measures to minimize the risk for the development of pressure injuries for 1 of 3 residents (R58) reviewed for pressure injuries. Findings include:	F 686	R58 cares were provided by staff per care plan on 9/29/21 as 1:06pm per State Surveyor observations and interviews. Resident's care plan has been reviewed and updated as needed. Policy and Procedures reviewed and revised as needed.	11/10/21

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F 686	Continued From page 21 R58's quarterly Minimum Data Set (MDS) dated 7/27/21, included severe cognitive impairment with diagnoses including, diabetes, dementia and a stoke with hemiplegia/paresis (weakness or paralysis on one side). R58 required extensive staff assistance with bed mobility, hygiene and dressing and did not refuse cares. R58 was at risk for pressure ulcers. R58's care plan dated 7/28/21, indicated R58 had an activities of daily living (ADL) deficit. Interventions indicated to assist R58 into his wheelchair after breakfast and back into bed before lunch. The care plan indicated R58 was to have Prevalon boots (special boots that off-load the heels to prevent pressure on them) on both feet. The care plan also indicated to turn/reposition R58 every two to three hours and heel lift boots should have been applied at all times. The care plan indicated R58's brief was to be checked and changed after breakfast and before lunch. The care plan further indicated R58 had a potential for pressure ulcer development. Interventions included to follow facility protocols for the prevention of skin breakdown, to encourage small, frequent position changes, and to administer all treatments as ordered. R58's Kardex (nurse aide worksheet) dated 9/16/21, indicated R58 required a total assist for bed mobility and should have been repositioned every 2-3 hours with boots applied to R58's feet. R58's Order Summary dated 1/3/20, indicated R58 should have had Prevalon boots on both feet, every shift, for wound prevention. R58's Provider Progress Note dated 7/15/21, indicated R58 was lying in bed, not wearing	F 686	Care Plans of residents that require assistance with turning and repositioning and the need for incontinence care have been reviewed and revised to ensure accuracy. Nursing staff will be educated on following skin interventions per Kardex and Care Plan. Monitoring to ensure compliance will be ensured through random weekly audits of resident repositioning per care plan and placement of adaptive interventions. Audits will continue for a minimum or 8 weeks. The facility QAPI committee will review audit results and make further recommendations. Director of Nursing or designee will be responsible for ensuring compliance.	

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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 injuries) on his feet as ordered for 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 p.m. RN-O entered R58's room to flush R58's

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feeding tube then left. R58 remained supine in bed at a 30-degree angle with no boots applied to his feet. At 12:15 p.m. RN-O returned to R58's room and applied eye drops to R58's eyes then left without repositioning R58. R58 was observed supine, in bed at a 30-degree angle with no pressure relieving boots on his feet until 12:45 p.m.

During an interview on 9/29/21, at 12:46 p.m. NA-L stated residents should be repositioned and their briefs checked every two hours. NA-L stated she had not repositioned or checked R58's brief since around 8:00 a.m. or 8:30 a.m. NA-L stated she would go back to assist R58 after lunch. NA-L further stated R58 could get "bed sores" or contracted if he was not repositioned or changed frequently. NA-L stated she did not know what the care sheet indicated regarding the Prevalon boots, but that R58 preferred to wear them at night and often kicked them off during the day.

During an interview on 9/29/21, at 1:00 p.m. RN-O stated residents should be repositioned and their briefs checked every two hours to avoid skin breakdown.

During an observation and interview on 9/29/21, at 1:06 p.m. RN-O and NA-L entered R58's room to provide pericare and change R58's brief. RN-O and NA-L repositioned R58 in bed. NA-L took the Prevalon boots out of R58's closet and applied them to R58's feet. R58 had a blanchable, circular, red spot approximately three centimeters in diameter to his left heel. RN-O stated she had not seen the red spot on R58's heel previously.

During an observation on 9/30/21, at 4:20 p.m. R58 was supine in bed, visiting with family. R58's

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F 686	Continued From page 24 Prevalon boots were on R58's wheelchair under a blanket. During an interview on 9/30/21, at 1:54 p.m. the director of nursing (DON) stated staff should follow each resident's changing and repositioning schedule. The DON stated if a resident had an order for Prevalon boots to be applied every shift, the boots should have been on the resident's feet. The DON also stated the nurse should have documented a resident's refusal to get out of bed or be repositioned, and notified the Interdisciplinary Team (IDT) to conduct an evaluation of the resident. The DON further stated if Prevalon boots weren't worn and/or a resident was not repositioned as scheduled, the resident could have skin breakdown. The facility Skin and Wound Care policy revised 8/1/19, indicated staff were to ensure residents admitted to the facility received care to prevent pressure ulcers from developing. The policy also indicated physician orders and/or pressure relieving nursing interventions were to be implemented when a compromised skin integrity was observed.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		11/10/21

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F 690	Continued From page 25 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure urinary catheter care was provided, to prevent contamination and potential urinary tract infection (UTI) for 1 of 3 residents (R186) reviewed for catheter cares. Findings include: R186's annual Minimum Data Set (MDS) dated 9/1/21, indicated R186 required extensive assistance with one person physical assist for	F 690	R186 had catheter cares provided and dark urine reported to provider. Care plan has been reviewed and revised as needed. Policies and procedures reviewed and updated as needed. Care plans for all residents with indwelling catheters have been reviewed and updated as needed.	

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F 690	Continued From page 26 bed mobility, dressing, eating, toileting, personal hygiene, bathing, and ability to move his wheelchair, and total dependence for transfers with assistance of 2 people. The MDS also indicated a diagnosis of neurogenic bladder and obstructive uropathy, requiring a long term indwelling foley catheter. R186's face sheet dated 9/30/21, indicated diagnosis of chronic kidney disease, a history of urinary tract infections, retention of urine, and obstructive and reflux uropathy. R186's Orders Summary Sheet dated 1/7/19, indicated catheter care was to be provided three times daily, and after every bowel movement. R186's care plan dated 5/28/21, indicated nurses should report deepening of urine color to the provider and also indicated to perform catheter care every shift and after every bowel movement. R186's Medication Administration Record (MAR) dated 3/24/20, directed staff to document urine output every shift. R186's Provider Note dated 8/10/21, from registered nurse (RN)-J indicated R186 had a urinary tract infection (UTI) with staphylococcus aureas. R186 completed an antibiotic, Docycycline hyclate 100 milligrams (mg) that was administered twice daily for 7 days, prescribed for UTI on 8/9/21. When interviewed on 9/29/21, at 2:30 p.m. RN-I indicated nurses do the catheter changes for R186, and catheter care was scheduled every shift.	F 690	Nursing staff will be educated regarding catheter cares including the proper procedure for emptying and maintenance. Monitoring for compliance will be ensured through random weekly observational audits for a minimum of 8 weeks. Facility QA&A Committee will review audit results and make further recommendations. Director of Nursing or designee will be responsible for ensuring compliance.	

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During observation on 9/30/21, at 9:01 a.m. R186's urine color in the bag appeared to be a dark brown color. RN-H indicated catheter care would be performed by afternoon shift, and not by her.

When interviewed on 9/30/21, at 1:34 p.m. RN-H reviewed the catheter care orders, tasks, and care plans. RN-H stated she did not know R186 required catheter care 3 times a day and with bowel movements, and stated she would provide the care after the aide assisted R186 into bed to rest.

During observation on 9/30/21, at 1:42 p.m. RN-H related R186 was very susceptible to UTI and stated she would report the dark urine to the next shift, and push fluids if she could. RN-H indicated she would assess R186's temperature and vital signs (VS). Nursing assistant (NA)- F was in the room and assisted with R186's personal cares and reported to RN-H 186's urine was not normally as dark as it was at that time. RN-H stated when in doubt about a resident she did not know very well, she should notify a provider of changes.

During observation at 9/30/21, at 1:42 p.m. NA-F emptied R186's catheter bag with 350 cubic centimeters (cc) output. After cleaning NA-F did not clean the catheter outflow drainage port (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

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F 690	Continued From page 28 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. Catheter Care Policy, dated 5/1992, and revised 8/1/2013, indicated to empty the bag into a collection container and cleanse the cap at the end of the catheter connection.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		11/10/21

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F 761	Continued From page 29 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure medications were stored and secured safely for 1 of 20 resident (R474) who was reviewed for medication storage and labeling. In addition, the facility failed to remove expired or discontued medications and maintain medication refrigerator temperatures in the appropriate range for 7 of 20 residents (R55, R422, R455, R466, R477, R488 and R499) reviewed for medication storage. Findings include: During an observation on 9/30/21, at 8:09 a.m. registered nurse (RN)-M was observed to walked nurse RN-M walked away from the medication cart to assist another nurse. The medication cart was left unlocked and medications were left un top of the cart unattended. Two residents were within five feet of the unlocked cart and two housekeeping staff walked pasted the medication cart. RN-M was away from the medication and cart for roughly 4 minutes. The medications which had been left on top of the	F 761	R474 medications were reviewed and discarded as needed. A whole house audit of medication carts, medication rooms and medication refrigerators will be conducted on or prior to 11/10/21. All expired, improperly labeled or otherwise improperly stored medications will been removed and properly destroyed. Medication storage policy and procedure reviewed and remains appropriate. Licensed Nurses educated on the proper storage of medications including ensuring medications are not left unattended, medications are dated at time they are opened, medications are disposed of at the time of discharge and monitoring the temperature of medication refrigerators Monitoring for compliance will be ensured through random weekly audits of medication carts and medication	

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F 761	Continued From page 30 medication cart included: -Lasix (treat fluid retention (edema) and swelling caused by congestive heart failure) -gabapentin (anti-epileptic medication used to treat seizures) -metoprolol (can treat high blood pressure, chest pain (angina), and heart failure) -citalopram (used to treat depression) -Asparte insulin (hormone that works by lowering levels of glucose) -Lantus insulin (helps control high blood sugar levels) -Flonase (nasal spray relieves sneezing, itchy, watery eyes and runny nose, plus nasal congestion) During an interview on 9/30/21, at 8:18 a.m. RN-M stated he left the cart to help another nurse. RN-M further stated he was educated on medication administration and storage to not leave medications on top of the medication cart or leave the medication cart unlocked. RN-M stated someone could have taken the medications when left unattended. During an interview on 9/30/21, at 8:48 a.m. with RN-E stated medications should not be left on the cart and the medication cart should not be left unlocked and the nurse should not walk away and leave the medications unattended. RN-E further stated a resident or a staff member could take the medications. During an interview on 9/30/21, at 1:00 p.m. the assistant director of nursing (ADON) stated medications should never be left on top of the medication cart or the cart unlocked without the nurse in proximity to the cart. ADON further	F 761	refrigerators. Audits will continue for a minimum of 8 weeks. Facility QAPI Committee will review audit results and make further recommendations. Director of Nursing or deesignee will be responsible for ensuring compliance.	

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stated leaving the medications out could put people at risk for accidental ingestion. ADON stated her expectation would be for nursing staff to secure medications and cart before walking away.

Facility's policy Medication Storage in The Facility undated, indicated ensure accurate, safe, and timely administration of drugs to our residents, and to ensure safe storage of supplies. The facility's policy directed the nurse to carry the cart keys at all times while on duty.

During an interview and observation of the fifth floor, odd side of hall, medication cart on 9/30/21, at 12:12 p.m. a bottle of saline eye drops was found with R55's name, medical record number, and birthdate on it. The bottle was half empty with no date indicating when it was opened. Registered nurse (RN)-Q verified the original packaging with the pharmacy label was not in the medication cart. RN-Q stated he did not know when the eye drops were opened and therefore, did not know when they would expire.

During an interview and observation of the fifth-floor medication room on 9/30/21, at 12:26 p.m. a bottle of liquid lorazepam (a narcotic) was found in the refrigerator belonging to R422, whom RN-Q stated had passed away, "awhile a go." The lorazepam was filled by the pharmacy on 8/11/21. The thermometer in the refrigerator indicated the temperature was 50 degrees Fahrenheit. RN-K verified the temperature and stated she did not know what the correct temperature should be. Various insulin's belonging to R455, R466 and R477 were in the refrigerator, which would expire within 28 days of

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not being held at refrigerator temperature of 35-45 degrees Fahrenheit.

During an interview and observation of the fourth-floor medication room on 9/30/21, at 12:50 p.m. a bottle of tuberculin (injected to detect tuberculosis) had an open date of 7/26/21. RN-R stated she was unsure how long tuberculin was good for after it was opened. The solution could be used for staff or any newly admitted residents. A box of Tylenol suppositories was also observed in the refrigerator with an expiration date of 5/2021. The Tubersol Purified Protein Derivative solution package insert indicated it was to be stored at 35-46 degrees Fahrenheit, and was good only 30 days after opening the solution.

During an interview and observation of the third-floor medication room on 9/30/21, at 1:15 p.m. ertapenem (an antibiotic) with an expiration date of 9/10/21, and an insulin pen with an expiration date of 9/2022, belonging to two different residents, R488 and R499, who had discharged from the facility, were found in the refrigerator. Also observed was an opened box of Aller-ease, a stock allergy medication, with an expiration date of 7/2020. RN-B stated the nurse managers destroyed medications and RN-B was did not know the process.

The medication-refrigerator temperature logs for all medication rooms that were observed, (sixth, fifth, fourth, and third floors) were incomplete.

The facility Medication Storage policy dated 12/7/16, indicated outdated medications were to be immediately removed from stock and disposed of according to policy. The policy also indicated medications that required refrigeration were to be

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F 761	Continued From page 33 kept between 36-46 degrees Fahrenheit.	F 761		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		11/10/21

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F 880	Continued From page 34 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to place a newly admitted 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	F 880	R263 was identified with a yellow wrist band and was placed on COVID quarantine precautions per CDC guidelines. All residents residing on the affected unit were tested for COVID-19 on 09/27/2021. All were found to be negative.	

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F 880	Continued From page 35 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 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 residents who are new admissions or readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission." The guidance also requires staff to wear full personal protective equipment (PPE),	F 880	Facility COVID Observation Policy and Procedure was reviewed and revised. Staff of all disciplines were educated on 09/27/21 and ongoing related to the use of a yellow wrist band to identify those residents on active COVID Quarantine and the need to re-direct quarantined residents to their room if they should break quarantine. All staff also received education on 9/27/21 related to hand hygiene and on the appropriate PPE to care for a resident on Quarantine. Staff of all disciplines will be re-educated on or before 11/10/21 on the appropriate PPE to wear in patient care areas while COVID-19 pandemic continues. Monitoring for compliance will be ensured through random weekly audits of newly admitted unvaccinated residents on quarantine. These audits will continue for a minimum of 8 weeks. Random daily audits will also be conducted for 14 days then weekly for 6 weeks to ensure all staff are compliant with wearing all appropriate PPE in patient care areas. Facility QAPI Committee will review audit results and make further recommendations. Director of Nursing or designee will be	

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F 880	Continued From page 36 including gowns, gloves, eye protection and an N95 or higher-level respirator for residents on the 14 day quarantine. R263's admission Minimum Data Set (MDS) dated 9/25/21, included 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. R236's Admission Record identified R236 had been admitted on 9/20/21, and had not been vaccinated against COVID-19. R263's care plan dated 9/20/21, included, "The resident requires transmission based precautions related to potential pre-admission COVID-19 exposure for the first 14 days from admission and/or an actual positive COVID-19 test result." Staff were directed, "Follow DROPLET PRECAUTIONS when caring for this resident." R263's physician order summary dated 9/28/21, included, "Patient on observation until 10/4/21. Encourage patient to wear mask in common areas. Wear observation PPE with close contact. Socially distance resident at meal times, every shift until 10/4/21." R263's nursing assistant worksheet, 3 Gamble Group 1, dated 9/24/21, included R263 was to be on observation until 10/4/21. During observation on 9/27/21, at 1:56 p.m. R263 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	F 880	responsible for ensuring compliance.	

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F 880	Continued From page 37	F 880		

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 went 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 stated wasn't aware of R263 being on any type of precautions. Further, verified R263 should have worn a mask while out of the room and PPE such

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as a gown and gloves should have been worn while working with R263.

During observation on 9/28/21, at 10:17 a.m. R263 was sitting in the TV room with 5 other residents with no mask on. All residents were closer than 6 feet apart.

When interviewed on 9/28/21, at 11:00 a.m. the director of therapy stated the therapy staff should treat any resident on precautions in the room if able. Further, the director of therapy stated the therapists would know who is on precautions by a sign on the residents door.

When interviewed on 9/28/21, at 11:10 a.m. registered nurse infection preventionist (RN)-B stated any resident admitted who was not fully vaccinated or unvaccinated, was to be placed on observation precautions and full personal protective equipment (PPE) was to be worn since the residents may have COVID-19, such as gown, gloves, mask, and eyewear. Secondly, RN-B stated, all observation and isolation rooms should have an isolation cart at the doorway with a TBP sign inside the drawer to indicate what PPE is to be used for the resident and what TBP the resident is on. Further, RN-B stated therapy should know who is on precautions and what PPE to use according to their treatment plan, There was no other communication to other departments except for the signs by the doors. R236 did not have a sign or cart by her bedroom door. RN-B confirmed R263 had not been vaccinated against COVID-19 and should have been placed on the 14 day quarantine, which should have been enforced by staff.

During observation on 9/28/21, at 1:35 p.m. R263

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	245055	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880		

was sitting in the TV room with no mask on with 5 other residents. All residents were within 6 feet of each other.

When interviewed on 9/28/21, at 1:36 p.m. nursing assistant (NA)-A stated they were not aware R263 was still on quarantine precautions. NA-A stated R263 was cooperative and would wear a mask if asked.

When interviewed on 9/28/21, at 1:38 p.m. RN-C stated they did not know why R263 had not been quarantined or encouraged to wear a mask while out of the room today. RN-C verified R263 should be quarantined to room and if needed to come out of room should be encouraged to wear a mask.

When interviewed on 9/28/21, at 1:50 p.m. licensed practical nurse (LPN)-B stated they had not made any attempt to quarantine R263 in her room because, "this is a dementia unit."

The facility Screening and Surveillance of resident infection prevention policy dated 8/30/21, indicated the purpose of the surveillance of COVID-19 is to guide appropriate interventions and to prevent the spread of COVID-19. Further, indicated a resident that doesn't have a history of testing positive for COVID-19, or is not fully vaccinated, would be placed in a private room and be quarantined for 14 days.

The PPE Requirements for Health Care Workers Infection Control Policy dated 6/28/21, indicated eye protection, masks, gowns, and gloves would be worn for residents with suspected or confirmed cases of COVID-19 by healthcare personnel.

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F 880	Continued From page 40 The IJ which began on 9/27/21, was removed on 9/29/21, after the facility implemented a removal plan which included the following actions: all residents on the affected unit were tested for COVID-19, the facility updated their observation policy, all residents on quarantine/isolation had signage placed on door, a yellow wrist band placed, staff were educated and notified of need for education prior to working next shift. Verification of implementation of the removal plan was completed by observation, interview and document review. During an observation on 9/28/21, at 8:45 a.m. nursing assistant NA-K was observed delivering meals wearing mask under nose his nose and was not wearing eye protection. When interviewed NA-K stated he had forgotten to put on his eye protection and knew his mask should be over his nose. During an observation nursing on 9/28/21 at 8:52 a.m. NA-J entered a resident's room with no eye protection.	F 880		

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F 880	Continued From page 41	F 880		

During an observation on 9/28/21, at 8:53 a.m. NA-E was observed without eye protection and entering residents room delivering meals. When interviewed NA-E stated she forgot to wear her goggles and was aware she needed them.

During observation on 9/28/21, at 8:58 a.m. RN-L had goggles on down on the tip of her nose not covering her eyes. RN-L stated she had a hard time wearing the goggles closer to her face because the goggles would fall when she would look downward. RN-L stated she was educated on wearing the goggles to protect her eyes.

R61's quarterly MDS dated 7/26/21, indicated R61 had a BIMS of 14 with intact cognition. The MDS also indicated R61 required extensive assistance for toileting and personal hygiene.

During observation on 9/27/21, at 1:09 p.m. NA-L entered R61's room, donned gloves, removed R61's soiled incontinent brief, performed pericare, and applied barrier cream to the perineum. NA-L then without removing gloves or performing hand hygiene applied a clean incontinent brief, pulled the covers over R61, placed the television remote control on the resident, and pulled the bedside table to R61. Then NA-L removed her gloves and performed hand hygiene. When interviewed NA-L stated she should have removed her gloves and washed her hands between the dirty and clean tasks.

During an interview on 9/30/21, at 1:54 p.m. the director of nursing (DON) stated staff should perform hand hygiene when going from dirty to clean during resident cares; this included after applying cream to a resident's bottom and groin.

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F 880	Continued From page 42 The DON stated staff should remove their gloves, wash their hands or use hand sanitizer, then put on new gloves before continuing with cares. 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.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the cleanliness of feeding tube poles for 2 of 3 residents (R58 and R150) residents reviewed for tube feeding. Findings include: R58's quarterly Minimum Data Set (MDS) dated 7/27/21, included severe cognitive impairment and received a tube feeding. During an observation on 9/29/21, at 9:34 a.m. a bottle of tube feeding formula was hanging from a metal pole and formula was infusing into R58's gastric tube. The metal pole had dried formula drippings on it and dried formula splatter on the base of the pole. There was also dried formula drippings on the face of the pump. During an observation and interview on 9/29/21,	F 921	The tube feeding poles in the rooms of R58 & R150 were on 10/01/2021. All additional tube feeding poles and equipment were inspected an cleaned as needed. Licensed nurses have received education on keeping the equipment used in enteral feedings clean and sanitary. Monitoring for compliance will be ensured through weekly audits of tube feeding poles and equipment to ensure they are clean and free of spilled tube feeding solution. Audits will be completed for a minimum of 8 weeks. Facility QAPI Committee will review audit results and make further recommendations.	11/10/21

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F 921	Continued From page 43 at 12:09 p.m. registered nurse (RN)-O entered R58's room to perform gastric tube cares. RN-O stated the dried formula on R58's tube feeding pole and pump should not be there and was not considered sanitary. R150's R150's annual MDS dated 8/26/21, included cognitively intact and received a tube feeing. During an observation and interview on 9/28/21, at 10:53 a.m. a 1500 ml bottle of tube feeding formula with tubing attached, was found hanging from a metal pole next to R150's bed. Multiple drippings of dried formula ran down the pole and dried splatter of formula was on the base of the pole. Also observed were drippings of dried formula across the face of the tube feeding pump. RN-P acknowledged the dried formula on the equipment and stated it was not sanitary and should have been cleaned. RN-P further stated any staff member could have cleaned the equipment. 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. During an observation on 9/29/21, at 2:30 p.m. the same dried formula drippings and splatter was observed on the pole, base, electrical cord, and pump in R150's room. During an interview on 9/30/21, at 1:54 p.m. the director of nursing (DON) stated drippings and splatter from tube feeding formula should have been cleaned up immediately by the nurse administering the tube feeding and should not	F 921	Director of Nursing or designee will be responsible for ensuring compliance.	

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F 921	Continued From page 44 have been left to dry for multiple days. The DON further stated dried formula on equipment was not sanitary. A facility policy on cleaning equipment was requested but not provided.	F 921		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

Kamala Fiske-Downing
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00276	A. BUILDING: _____ B. WING _____	C 09/30/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/27/21, through 9/30/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be unsubstantiated: H5055303C (MN58217) (MN58155), H5055298C (MN66507), H5505305C (MN52293), H5055300C (MN63946), H5055302C (MN62631), H5055294C (MN52812), H5055293C (MN54624), H5055296C (MN56183), H5055295C (MN57004), H5055304C (MN59811), H5055297C (MN64144), H5055297C (MN64286), H5055301C (MN67221) 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 Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box 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. 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.	2 000		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure urinary	2 835	Correction date on or before 11/10/2021	11/10/21

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2 835	Continued From page 3	2 835		

catheter care was provided, to prevent contamination and potential urinary tract infection (UTI) for 1 of 3 residents (R186) reviewed for catheter cares.

Findings include:

R186's annual Minimum Data Set (MDS) dated 9/1/21, indicated R186 required extensive assistance with one person physical assist for bed mobility, dressing, eating, toileting, personal hygiene, bathing, and ability to move his wheelchair, and total dependence for transfers with assistance of 2 people. The MDS also indicated a diagnosis of neurogenic bladder and obstructive uropathy, requiring a long term indwelling foley catheter.

R186's face sheet dated 9/30/21, indicated diagnosis of chronic kidney disease, a history of urinary tract infections, retention of urine, and obstructive and reflux uropathy.

R186's Orders Summary Sheet dated 1/7/19, indicated catheter care was to be provided three times daily, and after every bowel movement.

R186's care plan dated 5/28/21, indicated nurses should report deepening of urine color to the provider and also indicated to perform catheter care every shift and after every bowel movement.

R186's Medication Administration Record (MAR) dated 3/24/20, directed staff to document urine output every shift.

R186's Provider Note dated 8/10/21, from registered nurse (RN)-J indicated R186 had a urinary tract infection (UTI) with staphylococcus aureas. R186 completed an antibiotic,

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2 835	Continued From page 4 Docycycline hyclate 100 milligrams (mg) that was administered twice daily for 7 days, prescribed for UTI on 8/9/21. When interviewed on 9/29/21, at 2:30 p.m. RN-I indicated nurses do the catheter changes for R186, and catheter care was scheduled every shift. During observation on 9/30/21, at 9:01 a.m. R186's urine color in the bag appeared to be a dark brown color. RN-H indicated catheter care would be performed by afternoon shift, and not by her. When interviewed on 9/30/21, at 1:34 p.m. RN-H reviewed the catheter care orders, tasks, and care plans. RN-H stated she did not know R186 required catheter care 3 times a day and with bowel movements, and stated she would provide the care after the aide assisted R186 into bed to rest. During observation on 9/30/21, at 1:42 p.m. RN-H related R186 was very susceptible to UTI and stated she would report the dark urine to the next shift, and push fluids if she could. RN-H indicated she would assess R186's temperature and vital signs (VS). Nursing assistant (NA)- F was in the room and assisted with R186's personal cares and reported to RN-H 186's urine was not normally as dark as it was at that time. RN-H stated when in doubt about a resident she did not know very well, she should notify a provider of changes. During observation at 9/30/21, at 1:42 p.m. NA-F emptied R186's catheter bag with 350 cubic centimeters (cc) output. After cleaning NA-F did not clean the catheter outflow drainage port	2 835		

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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. Catheter Care Policy, dated 5/1992, and revised 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 and determine the need for further	2 835		

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2 835	Continued From page 6 education/monitoring/compliance. TIME PERIOD FOR CORRECTION: (21) days.	2 835		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to implement pressure injury measures to minimize the risk for the development of pressure injuries for 1 of 3 residents (R58) reviewed for pressure injuries. Findings include: R58's quarterly Minimum Data Set (MDS) dated 7/27/21, included severe cognitive impairment with diagnoses including, diabetes, dementia and a stoke with hemiplegia/paresis (weakness or paralysis on one side). R58 required extensive staff assistance with bed mobility, hygiene and dressing and did not refuse cares. R58 was at risk for pressure ulcers. R58's care plan dated 7/28/21, indicated R58 had an activities of daily living (ADL) deficit. Interventions indicated to assist R58 into his	2 905	Correction date on or before 11/10/2021	11/10/21

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2 905	Continued From page 7	2 905		

wheelchair after breakfast and back into bed before lunch. The care plan indicated R58 was to have Prevalon boots (special boots that off-load the heels to prevent pressure on them) on both feet. The care plan also indicated to turn/reposition R58 every two to three hours and heel lift boots should have been applied at all times. The care plan indicated R58's brief was to be checked and changed after breakfast and before lunch. The care plan further indicated R58 had a potential for pressure ulcer development. Interventions included to follow facility protocols for the prevention of skin breakdown, to encourage small, frequent position changes, and to administer all treatments as ordered.

R58's Kardex (nurse aide worksheet) dated 9/16/21, indicated R58 required a total assist for bed mobility and should have been repositioned every 2-3 hours with boots applied to R58's feet.

R58's Order Summary dated 1/3/20, indicated R58 should have had Prevalon boots on both feet, every shift, for wound prevention.

R58's Provider Progress Note dated 7/15/21, indicated R58 was lying in bed, not wearing 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

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2 905	Continued From page 8	2 905		

have Prevalon boots (a soft boot worn to prevent pressure injuries) on his feet as ordered for 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 p.m. RN-O entered R58's room to flush R58's feeding tube then left. R58 remained supine in bed at a 30-degree angle with no boots applied to his feet. At 12:15 p.m. RN-O returned to R58's room and applied eye drops to R58's eyes then left without repositioning R58. R58 was observed supine, in bed at a 30-degree angle with no pressure relieving boots on his feet until 12:45 p.m.

During an interview on 9/29/21, at 12:46 p.m. NA-L stated residents should be repositioned and their briefs checked every two hours. NA-L stated she had not repositioned or checked R58's brief since around 8:00 a.m. or 8:30 a.m. NA-L stated

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2 905	Continued From page 9	2 905		

she would go back to assist R58 after lunch. NA-L further stated R58 could get "bed sores" or contracted if he was not repositioned or changed frequently. NA-L stated she did not know what the care sheet indicated regarding the Prevalon boots, but that R58 preferred to wear them at night and often kicked them off during the day.

During an interview on 9/29/21, at 1:00 p.m. RN-O stated residents should be repositioned and their briefs checked every two hours to avoid skin breakdown.

During an observation and interview on 9/29/21, at 1:06 p.m. RN-O and NA-L entered R58's room to provide pericare and change R58's brief. RN-O and NA-L repositioned R58 in bed. NA-L took the Prevalon boots out of R58's closet and applied them to R58's feet. R58 had a blanchable, circular, red spot approximately three centimeters in diameter to his left heel. RN-O stated she had not seen the red spot on R58's heel previously.

During an observation on 9/30/21, at 4:20 p.m. R58 was supine in bed, visiting with family. R58's Prevalon boots were on R58's wheelchair under a blanket.

During an interview on 9/30/21, at 1:54 p.m. the director of nursing (DON) stated staff should follow each resident's changing and repositioning schedule. The DON stated if a resident had an order for Prevalon boots to be applied every shift, the boots should have been on the resident's feet. The DON also stated the nurse should have documented a resident's refusal to get out of bed or be repositioned, and notified the Interdisciplinary Team (IDT) to conduct an evaluation of the resident. The DON further stated if Prevalon boots weren't worn and/or a

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2 905	Continued From page 10 resident was not repositioned as scheduled, the resident could have skin breakdown. The facility Skin and Wound Care policy revised 8/1/19, indicated staff were to ensure residents admitted to the facility received care to prevent pressure ulcers from developing. The policy also indicated physician orders and/or pressure relieving nursing interventions were to be implemented when a compromised skin integrity was observed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, revise, and implement policies and procedures to ensure residents are repositioned in a timely manner and pressure relieving devices are in place, based upon residents' assessed needs. The DON or designee could educate staff on the policies and procedures and conduct audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to place a newly admitted	21375	Correction date on or before 11/10/2021	11/10/21

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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 jeopardy, the facility failed to ensure staff 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

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residents who are new admissions or readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission." The guidance also requires staff to wear full personal protective equipment (PPE), including gowns, gloves, eye protection and an N95 or higher-level respirator for residents on the 14 day quarantine.

R263's admission Minimum Data Set (MDS) dated 9/25/21, included 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.

R236's Admission Record identified R236 had been admitted on 9/20/21, and had not been vaccinated against COVID-19.

R263's care plan dated 9/20/21, included, "The resident requires transmission based precautions related to potential pre-admission COVID-19 exposure for the first 14 days from admission and/or an actual positive COVID-19 test result." Staff were directed, "Follow DROPLET PRECAUTIONS when caring for this resident."

R263's physician order summary dated 9/28/21, included, "Patient on observation until 10/4/21. Encourage patient to wear mask in common areas. Wear observation PPE with close contact. Socially distance resident at meal times, every shift until 10/4/21."

R263's nursing assistant worksheet, 3 Gamble Group 1, dated 9/24/21, included R263 was to be on observation until 10/4/21.

During observation on 9/27/21, at 1:56 p.m. R263

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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 went 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

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21375	Continued From page 14 stated wasn't aware of R263 being on any type of precautions. Further, verified R263 should have worn a mask while out of the room and PPE such as a gown and gloves should have been worn while working with R263. During observation on 9/28/21, at 10:17 a.m. R263 was sitting in the TV room with 5 other residents with no mask on. All residents were closer than 6 feet apart. When interviewed on 9/28/21, at 11:00 a.m. the director of therapy stated the therapy staff should treat any resident on precautions in the room if able. Further, the director of therapy stated the therapists would know who is on precautions by a sign on the residents door. When interviewed on 9/28/21, at 11:10 a.m. registered nurse infection preventionist (RN)-B stated any resident admitted who was not fully vaccinated or unvaccinated, was to be placed on observation precautions and full personal protective equipment (PPE) was to be worn since the residents may have COVID-19, such as gown, gloves, mask, and eyewear. Secondly, RN-B stated, all observation and isolation rooms should have an isolation cart at the doorway with a TBP sign inside the drawer to indicate what PPE is to be used for the resident and what TBP the resident is on. Further, RN-B stated therapy should know who is on precautions and what PPE to use according to their treatment plan, There was no other communication to other departments except for the signs by the doors. R236 did not have a sign or cart by her bedroom door. RN-B confirmed R263 had not been vaccinated against COVID-19 and should have been placed on the 14 day quarantine, which should have been enforced by staff.	21375		

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21375	Continued From page 15 During observation on 9/28/21, at 1:35 p.m. R263 was sitting in the TV room with no mask on with 5 other residents. All residents were within 6 feet of each other. When interviewed on 9/28/21, at 1:36 p.m. nursing assistant (NA)-A stated they were not aware R263 was still on quarantine precautions. NA-A stated R263 was cooperative and would wear a mask if asked. When interviewed on 9/28/21, at 1:38 p.m. RN-C stated they did not know why R263 had not been quarantined or encouraged to wear a mask while out of the room today. RN-C verified R263 should be quarantined to room and if needed to come out of room should be encouraged to wear a mask. When interviewed on 9/28/21, at 1:50 p.m. licensed practical nurse (LPN)-B stated they had not made any attempt to quarantine R263 in her room because, "this is a dementia unit." The facility Screening and Surveillance of resident infection prevention policy dated 8/30/21, indicated the purpose of the surveillance of COVID-19 is to guide appropriate interventions and to prevent the spread of COVID-19. Further, indicated a resident that doesn't have a history of testing positive for COVID-19, or is not fully vaccinated, would be placed in a private room and be quarantined for 14 days. The PPE Requirements for Health Care Workers Infection Control Policy dated 6/28/21, indicated eye protection, masks, gowns, and gloves would be worn for residents with suspected or confirmed cases of COVID-19 by healthcare	21375		

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21375	Continued From page 16 personnel. The IJ which began on 9/27/21, was removed on 9/29/21, after the facility implemented a removal plan which included the following actions: all residents on the affected unit were tested for COVID-19, the facility updated their observation policy, all residents on quarantine/isolation had signage placed on door, a yellow wrist band placed, staff were educated and notified of need for education prior to working next shift. Verification of implementation of the removal plan was completed by observation, interview and document review. During an observation on 9/28/21, at 8:45 a.m. nursing assistant NA-K was observed delivering meals wearing mask under nose his nose and was not wearing eye protection. When interviewed NA-K stated he had forgotten to put on his eye protection and knew his mask should be over his nose. During an observation nursing on 9/28/21 at 8:52 a.m. NA-J entered a resident's room with no eye protection. During an observation on 9/28/21, at 8:53 a.m. NA-E was observed without eye protection and entering residents room delivering meals. When interviewed NA-E stated she forgot to wear her goggles and was aware she needed them. During observation on 9/28/21, at 8:58 a.m. RN-L had goggles on down on the tip of her nose not covering her eyes. RN-L stated she had a hard time wearing the goggles closer to her face because the goggles would fall when she would look downward. RN-L stated she was educated	21375		

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21375	Continued From page 17 on wearing the goggles to protect her eyes. R61's quarterly MDS dated 7/26/21, indicated R61 had a BIMS of 14 with intact cognition. The MDS also indicated R61 required extensive assistance for toileting and personal hygiene. During observation on 9/27/21, at 1:09 p.m. NA-L entered R61's room, donned gloves, removed R61's soiled incontinent brief, performed pericare, and applied barrier cream to the perineum. NA-L then without removing gloves or performing hand hygiene applied a clean incontinent brief, pulled the covers over R61, placed the television remote control on the resident, and pulled the bedside table to R61. Then NA-L removed her gloves and performed hand hygiene. When interviewed NA-L stated she should have removed her gloves and washed her hands between the dirty and clean tasks. During an interview on 9/30/21, at 1:54 p.m. the director of nursing (DON) stated staff should perform hand hygiene when going from dirty to clean during resident cares; this included after applying cream to a resident's bottom and groin. The DON stated staff should remove their gloves, wash their hands or use hand sanitizer, then put on new gloves before continuing with cares. 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 CORRECTION: The	21375		

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21375	Continued From page 18 DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program, including daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions to mitigate COVID-19 transmission, and ensure the appropriate use of PPE and prevented from working with symptoms of COVID-19 and cares are being performed appropriately and timely. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure medications were stored and secured safely for 1 of 20 resident (R474) who was reviewed for medication storage and labeling. In addition, the facility failed to remove expired or discontued medications and maintain medication refrigerator temperatures in	21610	Correction date on or before 11/10/2021	11/10/21

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the appropriate range for 7 of 20 residents (R55, R422, R455, R466, R477, R488 and R499) reviewed for medication storage.

Findings include:

During an observation on 9/30/21, at 8:09 a.m. registered nurse (RN)-M was observed to walked nurse RN-M walked away from the medication cart to assist another nurse. The medication cart was left unlocked and medications were left un top of the cart unattended. Two residents were within five feet of the unlocked cart and two housekeeping staff walked pasted the medication cart. RN-M was away from the medication and cart for roughly 4 minutes.

The medications which had been left on top of the medication cart included:
-Lasix (treat fluid retention (edema) and swelling caused by congestive heart failure)
-gabapentin (anti-epileptic medication used to treat seizures)
-metoprolol (can treat high blood pressure, chest pain (angina), and heart failure)
-citalopram (used to treat depression)
-Asparte insulin (hormone that works by lowering levels of glucose)
-Lantus insulin (helps control high blood sugar levels)
-Flonase (nasal spray relieves sneezing, itchy, watery eyes and runny nose, plus nasal congestion)

During an interview on 9/30/21, at 8:18 a.m. RN-M stated he left the cart to help another nurse. RN-M further stated he was educated on medication administration and storage to not leave medications on top of the medication cart

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or leave the medication cart unlocked. RN-M stated someone could have taken the medications when left unattended.

During an interview on 9/30/21, at 8:48 a.m. with RN-E stated medications should not be left on the cart and the medication cart should not be left unlocked and the nurse should not walk away and leave the medications unattended. RN-E further stated a resident or a staff member could take the medications.

During an interview on 9/30/21, at 1:00 p.m. the assistant director of nursing (ADON) stated medications should never be left on top of the medication cart or the cart unlocked without the nurse in proximity to the cart. ADON further stated leaving the medications out could put people at risk for accidental ingestion. ADON stated her expectation would be for nursing staff to secure medications and cart before walking away.

Facility's policy Medication Storage in The Facility undated, indicated ensure accurate, safe, and timely administration of drugs to our residents, and to ensure safe storage of supplies. The facility's policy directed the nurse to carry the cart keys at all times while on duty.

During an interview and observation of the fifth floor, odd side of hall, medication cart on 9/30/21, at 12:12 p.m. a bottle of saline eye drops was found with R55's name, medical record number, and birthdate on it. The bottle was half empty with no date indicating when it was opened. Registered nurse (RN)-Q verified the original packaging with the pharmacy label was not in the medication cart. RN-Q stated he did not know

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when the eye drops were opened and therefore, did not know when they would expire.

During an interview and observation of the fifth-floor medication room on 9/30/21, at 12:26 p.m. a bottle of liquid lorazepam (a narcotic) was found in the refrigerator belonging to R422, whom RN-Q stated had passed away, "awhile a go." The lorazepam was filled by the pharmacy on 8/11/21. The thermometer in the refrigerator indicated the temperature was 50 degrees Fahrenheit. RN-K verified the temperature and stated she did not know what the correct temperature should be. Various insulin's belonging to R455, R466 and R477 were in the refrigerator, which would expire within 28 days of not being held at refrigerator temperature of 35-45 degrees Fahrenheit.

During an interview and observation of the fourth-floor medication room on 9/30/21, at 12:50 p.m. a bottle of tuberculin (injected to detect tuberculosis) had an open date of 7/26/21. RN-R stated she was unsure how long tuberculin was good for after it was opened. The solution could be used for staff or any newly admitted residents. A box of Tylenol suppositories was also observed in the refrigerator with an expiration date of 5/2021. The Tubersol Purified Protein Derivative solution package insert indicated it was to be stored at 35-46 degrees Fahrenheit, and was good only 30 days after opening the solution.

During an interview and observation of the third-floor medication room on 9/30/21, at 1:15 p.m. ertapenem (an antibiotic) with an expiration date of 9/10/21, and an insulin pen with an expiration date of 9/2022, belonging to two different residents, R488 and R499, who had discharged from the facility, were found in the

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21610	Continued From page 22 refrigerator. Also observed was an opened box of Aller-ease, a stock allergy medication, with an expiration date of 7/2020. RN-B stated the nurse managers destroyed medications and RN-B was did not know the process. The medication-refrigerator temperature logs for all medication rooms that were observed, (sixth, fifth, fourth, and third floors) were incomplete. The facility Medication Storage policy dated 12/7/16, indicated outdated medications were to be immediately removed from stock and disposed of according to policy. The policy also indicated medications that required refrigeration were to be kept between 36-46 degrees Fahrenheit. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications including medication refrigerator temperatures. Nursing staff could be educated on the importance of properly storing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		11/10/21

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21665	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the cleanliness of feeding tube poles for 2 of 3 residents (R58 and R150) residents reviewed for tube feeding. Findings include: R58's quarterly Minimum Data Set (MDS) dated 7/27/21, included severe cognitive impairment and received a tube feeding. During an observation on 9/29/21, at 9:34 a.m. a bottle of tube feeding formula was hanging from a metal pole and formula was infusing into R58's gastric tube. The metal pole had dried formula drippings on it and dried formula splatter on the base of the pole. There was also dried formula drippings on the face of the pump. During an observation and interview on 9/29/21, at 12:09 p.m. registered nurse (RN)-O entered R58's room to perform gastric tube cares. RN-O stated the dried formula on R58's tube feeding pole and pump should not be there and was not considered sanitary. R150's R150's annual MDS dated 8/26/21, included cognitively intact and received a tube feeing. During an observation and interview on 9/28/21, at 10:53 a.m. a 1500 ml bottle of tube feeding formula with tubing attached, was found hanging from a metal pole next to R150's bed. Multiple drippings of dried formula ran down the pole and dried splatter of formula was on the base of the	21665	Correction date on or before 11/10/2021	

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21665	Continued From page 24 pole. Also observed were drippings of dried formula across the face of the tube feeding pump. RN-P acknowledged the dried formula on the equipment and stated it was not sanitary and should have been cleaned. RN-P further stated any staff member could have cleaned the equipment. 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. During an observation on 9/29/21, at 2:30 p.m. the same dried formula drippings and splatter was observed on the pole, base, electrical cord, and pump in R150's room. During an interview on 9/30/21, at 1:54 p.m. the director of nursing (DON) stated drippings and splatter from tube feeding formula should have been cleaned up immediately by the nurse administering the tube feeding and should not have been left to dry for multiple days. The DON further stated dried formula on equipment was not sanitary. A facility policy on cleaning equipment was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and revise policies concerning cleaning of resident equipment, educate staff, perform audits and bring to quality assurance meeting. TIME PERIOD FOR CORRECTION: 21 days.	21665		

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21805	Continued From page 25	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignified treatment for 2 of 4 residents (R59 and R47) reviewed, who had reported concerns related to staff treatment. Findings include: R59's quarterly Minimum Data Set (MDS) dated 7/21/21, included, cognitively intact, a diagnosis of heart failure and required extensive assistance from staff for ambulation and transfers. When interviewed on 9/27/21, at 1:11 p.m. R59 stated she felt, "invisible," when staff were in her room. R59 stated the staff enter the room without 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	21805	Correction date on or before 11/10/2021	11/10/21

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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 left R59 on the toilet without closing the door or pulling the privacy curtain. R59 could be seen from the hallway sitting on 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 ask if they needed anything else before they left the resident's room.

When interviewed on 9/30/21, at 4:57 p.m. the director of nursing (DON) stated all staff are to ensure all the resident's needs are met before they leave the room. DON stated all staff receive dignity training when they start working at the facility.

R47's quarterly MDS dated 7/13/21, included, cognitively intact with a diagnosis of diabetes and received insulin injections daily. R47 required extensive staff assistance with dressing and transfers.

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R47's care plan dated 7/14/21, indicated R47 was a vulnerable adult with a history of major depressive disorder related to anxiety and bi-polar with a preference to isolation. Interventions included allowing R47 to express feelings and providing a safe environment for R47.

R47's Order Summary Report dated 9/30/21, indicated blood glucose monitoring before meals. The report also indicated R47 received insulin aspart solution on a sliding scale by injection, with meals, and four units of NovoLog (insulin) by pen-injector, three times per day.

During observation on 9/30/21, at 8:21 a.m. RN-N stood next to R47, who was in the dining room and asked him loudly if he was having pain. There were 6 other residents in the area. R47 stated, "no." RN-N explained to R47 she needed to check his blood sugar and give him his insulin. RN-N wheeled R47's wheel chair to the hallway and faced him toward the dining room where other residents and staff were present. RN-N checked R47's blood sugar and lifted his shirt to expose his abdomen, still within eyesight of the entire dining room, and injected the insulin. When interviewed, RN-N stated they give medications in the dining room, "it is how it's always done."

When interviewed on 9/30/21, at 5:56 p.m. R47 stated he did not like receiving his insulin injection in the hallway where other people were walking by. R47 stated he would have preferred to have it administered in his room where it was private. It was embarrassing.

When interviewed on 9/30/21, at 1:54 p.m. the DON stated staff should provide residents privacy

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21805	Continued From page 28 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. The facility Quality of Life-Dignity policy, revised 8/1/19, indicated residents were to be treated with dignity and respect at all times by maintaining and enhancing residents' self-esteem. The policy indicated staff were to maintain an environment which protected resident's confidential, clinical information including conducting conversations outside the hearing range of other residents and the public. The policy also indicated staff should promote and protect resident privacy, including bodily privacy, during assistance with cares and treatments. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents are treated with dignity. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.	21810		11/10/21

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21810	Continued From page 29 This MN 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: 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 dated 9/10/21, indicated R150 was a vulnerable adult. Interventions included providing a safe environment for R150. The care plan indicated R150 had a communication 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 risk for falls. Interventions included ensuring the call light was within reach.	21810	Correction date on or before 11/10/2021	

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21810	Continued From page 30 During an observation and interview on 9/27/21, at 6:03 p.m. R150 was in bed wearing only a brief and no covers. R150 stated she was cold and needed a boost in bed. R150 was contracted with limited movement in all extremities. R150 was able to move her right hand slightly to activate her metal, triangle call light if it was attached to the sheet within her reach; however, the call light was hanging off the right side of the bed and R150 was unable to activate it or see it. During an observation on 9/28/21, at 11:01 a.m. R150's call light was turned around with the activation button facing away from R150. R150 was unable to activate her call button. At 11:05 a.m. registered nurse (RN)-P was notified about R150's call light. During an observation on 9/29/21, at 7:34 a.m. R150 activated the call light on her bed. At 7:35 a.m. nursing assistant (NA)-N entered R150's room to assist R150. R150 requested to be boosted in bed. NA-N left briefly and returned with NA-M. NA-N and NA-M boosted R150 in bed then attached the call light to the bed with the activation button facing away from R150. NA-N and NA-M left R150's room. R150 was unable to activate her call button. The facility Call Light policy revised 6/28/12, indicated all staff members were to ensure the call light was within easy reach for a resident when they are in bed. The policy further indicated a call light was not to be taken away from a resident. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00276	A. BUILDING: _____ B. WING _____	C 09/30/2021

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

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21810	Continued From page 31 develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		