



*Protecting, Maintaining and Improving the Health of All Minnesotans*

## Revised Letter

Electronically delivered

December 17, 2020

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

RE: CCN: 245055  
Cycle Start Date: November 13, 2020

**This letter will replace the letter dated December 1, 2020. The F880 tag was removed which left a survey with no deficiencies cited.**

Dear Administrator:

On November 13, 2020, a survey was completed at your facility by the Minnesota Department of Health 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The CMS-2567 is being electronically delivered.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads '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](mailto:Kamala.Fiske-Downing@state.mn.us)



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
December 1, 2020

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

RE: CCN: 245055  
Cycle Start Date: November 13, 2020

Dear Administrator:

On November 13, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

## **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(ies) 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:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 31, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 31, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 31, 2020.

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.

This Department is also recommending that CMS impose:

- 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.

### **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.

If you have not achieved substantial compliance by December 31, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Walker Methodist Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 31, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

### **ELECTRONIC PLAN OF CORRECTION (ePOC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. 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**  
**Metro C District Office**  
**Licensing and Certification Program**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**85 East Seventh Place, Suite 220**  
**P.O. Box 64900**  
**Saint Paul, Minnesota 55164-0900**  
**Email: 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 - 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 May 13, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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](mailto: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](mailto:Tamika.Brown@cms.hhs.gov).

Walker Methodist Health Center

December 1, 2020

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**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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing  
Minnesota Department of Health  
Licensing and Certification Program  
Program Assurance Unit  
Health Regulation Division  
Telephone: (651) 201-4112 Fax: (651) 215-9697  
Email: [kamala.fiske-downing@state.mn.us](mailto:kamala.fiske-downing@state.mn.us)

## **DIRECTED PLAN OF CORRECTION**

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

### **DIRECTED PLAN OF CORRECTION - Personal Protective Equipment (PPE)**

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

### **POLICIES/PROCEDURES/SYSTEM CHANGES:**

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for appropriate use of PPE for residents on 14 day quarantine who have returned from the hospital, LOA or are newly admitted.
- Review policies regarding standard and transmission based precautions and revise as needed.

### **TRAINING/EDUCATION:**

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

### **CDC RESOURCES:**

Infection Control Guidance: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html>

CDC: Isolation Precautions Guideline:

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

CDC: Personal Protective Equipment: <https://www.cdc.gov/niosh/ppe/>

Healthcare Infection Prevention and Control FAQs for COVID-19:

[https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html)

#### **MDH RESOURCES:**

Personal Protective Equipment (PPE) for Infection Control:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html>

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): <https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf>

Interim Guidance on Facemasks as a Source Control Measure (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/masksource.pdf>

Interim Guidance on Alternative Facemasks (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/maskalt.pdf>

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf>

Droplet Precautions:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html>

Airborne Precautions:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html>

#### **MONITORING/AUDITING:**

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits to ensure PPE is in use for all residents on quarantine.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this





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

PRINTED: 02/04/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>WALKER METHODIST HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409</b>		
(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  A COVID-19 Focused Infection Control survey was conducted on 11/12/20 through 11/13/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance 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			
F 000	INITIAL COMMENTS  On 11/12/20 through 11/13/20 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.  The following complaint was found to be SUBSTANTIATED: H5055256C, however, no citations were issued to actions taken by the facility prior to survey entrance.  The following complaints were found to be unsubstantiated: H5055253C, H5055254C and H5055255C.  In addition, A COVID-19 Focused Infection Control survey was conducted on 11/12/20 through 11/13/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was IN full compliance.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/18/2020

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.

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

PRINTED: 02/04/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>WALKER METHODIST HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3737 BRYANT AVENUE SOUTH</b> <b>MINNEAPOLIS, MN 55409</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.  Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	F 000			

**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245055	Provider/Supplier Name WALKER METHODIST HEALTH CTR
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Type of Survey (select all that apply):

A	K	M			
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- A Complaint Investigation
- B Dumping Investigation
- C Federal Monitoring
- D Follow-up Visit
- E Initial Certification
- F Inspection of Care
- G Validation
- H Life safety Code
- I Recertification
- J Sanction/Hearing
- K State License
- L Chow

Extent of Survey (Select all that apply):

A	D				
---	---	--	--	--	--

- A Routine/Standard (all providers/suppliers)
- B Extended Survey (HHA or long term care facility)
- C Partial Extended Survey (HHA)
- D Other Survey

**SURVEY TEAM AND WORKLOAD DATA**

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 43007	11-12-2020	11-13-2020	0.00	0.00	2.40	0.00	0.50	0.00
2. 43077			0.50	0.00	0.00	0.00	0.00	0.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.25

Total Clerical/Data Entry Hours..... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245055	Provider/Supplier Name WALKER METHODIST HEALTH CTR
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- L Chow

Extent of Survey (Select all that apply):

A					
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1. Team Leader 43007	11-12-2020	11-13-2020	0.00	0.00	2.40	0.00	0.50	0.00
2. 43079	11-12-2020	11-13-2020	0.25	0.00	2.50	0.00	0.00	1.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.25  
 Total Clerical/Data Entry Hours..... 2  
 Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245055	Provider/Supplier Name WALKER METHODIST HEALTH CTR
------------------------------------	---

Type of Survey (select all that apply):

A	K	M			
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- A Complaint Investigation
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- H Life safety Code
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- J Sanction/Hearing
- K State License
- L Chow

Extent of Survey (Select all that apply):

A	D				
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- A Routine/Standard (all providers/suppliers)
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**SURVEY TEAM AND WORKLOAD DATA**

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1. Team Leader 43007	11-12-2020	11-13-2020	0.00	0.00	2.40	0.00	0.50	0.00
2. 43079	11-12-2020	11-12-2020	0.25	0.00	1.50	0.00	0.00	1.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.25  
 Total Clerical/Data Entry Hours..... 2  
 Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245055	Provider/Supplier Name WALKER METHODIST HEALTH CTR
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Type of Survey (select all that apply):

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Extent of Survey (Select all that apply):

A	D				
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- A Routine/Standard (all providers/suppliers)
- B Extended Survey (HHA or long term care facility)
- C Partial Extended Survey (HHA)
- D Other Survey

**SURVEY TEAM AND WORKLOAD DATA**

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader 1. 43007	11-12-2020	11-13-2020	0.00	0.00	2.40	0.00	0.50	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 1.00  
 Total Clerical/Data Entry Hours..... 2  
 Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N