DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 5, 2021

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

RE: CCN: 245055
Cycle Start Date: December 7, 2020

Dear Administrator:

On December 29, 2020, we notified you a remedy was imposed. On January 25, 2021 the Minnesota Department of Health 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 January 20, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 13, 2021 be discontinued as of January 20, 2021. (42 CFR 488.417 (b))

Also, we notified you in our letter of December 29, 2020, 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 January 13, 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
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

Electronically delivered
January 12, 2021

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

RE: CCN: 245055
Cycle Start Date: December 7, 2020

Dear Administrator:

On December 29, 2020, we informed you of imposed enforcement remedies.

On December 28, 2020, the Minnesota Department of Health completed a survey 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 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 January 13, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 13, 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 December 29, 2020, 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 January 13, 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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro B 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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 June 7, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
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 12/28/2020

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 A COVID-19 Focused Infection Control survey was conducted from 12/23/20 through 12/28/20, 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS From 12/23/20 through 12/28/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5055264C/MN68329, with a deficiency cited at F692. The following complaint was found to be UNSUBSTANTIATED: H5055265C/MN68399. A COVID-19 Focused Infection Control survey was also conducted from 12/23/20 through 12/28/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was IN full compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.	F 000		

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

Electronically Signed | 01/18/2021

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 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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 692	Resident R1 was transferred to the	1/20/21

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F 692	Continued From page 2 facility failed to implement an ordered swallow evaluation/assessment which resulted in a decline of nutrition and hydration status for 1 of 3 residents (R1) reviewed for nutrition and hydration. This resulted in actual harm when R1 was admitted to the hospital with sepsis, pneumonia and dehydration that required intravenous hydration and nutrition therapy. Findings include: R1 was admitted to the facility on 12/4/20. R1's pre-admission history and physical progress notes indicated R1 had not been eating, drinking or taking medications. R1 had received palliative care and hospice evaluations but R1's family declined hospice care. R1's admission Minimum Data Set (MDS) dated, 12/10/20, identified R1 with severe cognitive impairment and required extensive assistance with eating. The MDS indicated no signs or symptoms of possible swallowing disorder. R1's diagnosis included non-Alzheimer's dementia, metabolic encephalopathy (a problem in the brain caused by chemical imbalance in the blood) and renal insufficiency (a condition in which the kidneys lose ability to remove waste). R1's nutritional assessment dated 12/7/20, identified R1 required a regular diet with regular textures and thin liquids. The assessment further identified R1 was completely dependent on staff to eat and had no difficulties with chewing or swallowing. The nutritional assessment was completed by the dietary technician (DT) who reviewed progress notes and spoke with R1's family. The nutritional assessment did not include any meal or intake observations of R1 by the DT	F 692	hospital prior to survey on December 14, 2020. Policies on Nutrition and Hydration have been reviewed and remain current. The DON or designee will re-educate licensed nurses, nursing assistants, dieticians and the IDT on hydration and nutrition policies. Furthermore the facility has identified and audited all residents who have an admitting history of poor intake, and or a current decline in nutritional intake as identified by the interdisciplinary team. These residents have been audited and reviewed to confirm all orders for Speech Therapy have been completed and additional Speech Therapy assessments have been performed as needed, and that both include proper documentation. Ongoing, Speech Language Pathology will screen all new admissions for speech/cognitive/swallow treatment needs and reduced nutritional intake. They will document their findings, their recommendations, and how they will monitor resident□s status throughout their stay in the Point Click Care Progress Notes. This change will go into effect 1/15/2021. In addition we have retro-actively reviewed admissions since 12/31/20, and have identified those without documentation of their Speech screen, and will enter late entry progress notes	

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F 692	Continued From page 3 or registered dietician (RD). R1's care plan initiated 12/4/20, identified R1 had a nutritional problem or potential nutritional problem and instructed staff to monitor, document and report any signs or symptoms of dysphagia (difficulty swallowing) or refusal to eat. Care plan further instructed registered dietician to evaluate and make diet change recommendations as needed. R1's physician order dated 12/4/20, indicated, "SLP: Eval and Tx [speech-language-pathologist to evaluate and treat]." R1's physician order dated 12/7/20, indicated, "Provide 120 cc [cubic centimeters] HNS [house nutrition supplement] TID [three times a day]. Document [percent] intake. Notify RD [registered dietician] if pt. refuses [times] 3." R1's progress notes dated 12/6/20, at 8:59 a.m. indicated R1 did not receive ordered medication because she "can't swallow" and "pushed and throws away food or med." R1's progress note dated 12/7/20, at 3:09 p.m. indicated, "Patient only taking a few bites at breakfast. Will spit out food and clench teeth together at times. Consumed 100 cc of ice cream and drank 60 cc of fluids...Call received and spoke with [R1's family member/F-A]. Updated on intake...Refusing to take medications. [F-A] stated patient likes ice cream and will only take a few bites at a time and then come back for more a while later. NP [nurse practitioner] here and updated on status. See new orders." R1's physician order for HNS was changed to magic cup (a nutritional supplement similar to ice cream	F 692	with the above data and perform additional assessments as needed. Speech Language Pathology will be educated that the expectation, when a provider orders an evaluation by Speech that cannot be completed, the SLP will notify the provider and document that communication in Point Click Care. When Speech Language Pathology receives an order for evaluation that cannot be completed, they will contact the provider to notify of findings and document this communication in Point Click Care. Interdisciplinary teams were educated on monitoring and reporting nutritional status concerns for all residents and reporting concerns to providers and or Speech Therapy. Concerns will be noted and followed via Clinical and IDT Meetings. We will audit all incoming admissions to check for Speech Progress Note for a period of 2 months, at which time the audits will be shared at the Health Center□s Quality Assurance group meeting to determine ongoing frequency. We will audit interdisciplinary team meeting notes 3 times a week to ensure provider was contacted for changes in nutritional needs for a period of 2 months, at which time the audits will be shared at the Health Center□s Quality Assurance	

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F 692	Continued From page 4 in flavor and texture). R1's progress notes dated 12/8/20, at 2:00 p.m. indicated, "Patient only taking a few bites at meals." R1's progress notes dated 12/9/20, at 1:17 p.m. indicated, "Patient only taking a few bites at meals." R1's progress note dated 12/10/20, at 9:12 p.m. indicated, "She has not been eating well, unable to open mouth, clinched her teeth during meals or pushing away staff hand when been [sic] fed. Exhibited the same behavior with med intake." R1's progress note dated 12/11/20, at 1:40 p.m. indicated, "Pt has poor diet intake." R1's progress note dated 12/12/20, at 8:43 p.m. indicated, "She refused both meds and meals-unable to open mouth, clinched her teeth during meals or pushing away staff hand when been [sic] fed." R1's progress note late entry dated 12/14/20, at 9:47 a.m. indicated nurse practitioner was updated on "patient not eating and only taking sips of fluids." R1's progress note dated 12/14/20, at 8:20 p.m. indicated "writer went to take pt her medication and she noted that pt was unable to swallow and that pt was not responding to verbal stimuli. Pt was not opening her eyes and periodically pt's arms and body will shake. Pt had shallow breathing RR [respiratory rate] 28 B/P [blood pressure] 103/63 P [pulse] 89 Oxygen 62-75% on RA [room air]. Oxygen administration was	F 692	group meeting to determine ongoing frequency. Director of Rehab or designee will complete audits of Speech Language Pathology Progress Notes. DON or designee will be responsible to complete audits of interdisciplinary team meeting notes and communication progress notes to ensure providers were contacted when nutritional needs changed.	

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F 692	Continued From page 5	F 692		

initiated and pt's oxygen came up to 95% on 2L NC [nasal cannula]. Writer updated [F-A] who was present in the room about her mom's status and she stated," I want to give her a fighting chance and stated that she is not ready for comfort cares." [F-A] was also on the phone with [F-B] who also indicated that they want immediate interventions and that they wanted their mother to be seen physically by the doctor. Writer paged on call...and was updated of the pt's status and pt's family wishes and she stated to send pt to the ER at 1857 [6:57 p.m.]... Emergency services were called... Pt left the facility at 1923 [7:23 p.m.] on a stretcher with the EMT [for the hospital]."

R1's Nutrition Amount Eaten record for 12/5/20 through 12/13/20, indicated R1 ate 0-25% of meal 17 times, 26-50% of meal 1 time, 51-75% of meal one time and refused four times. R1's Nutrition Amount Drank record indicated R1 had no fluid intake on two days and 120 cc or less on four days. The remaining three days, R1's record indicated R1 consumed 720 cc, 300 cc and 150 cc.

When interviewed on 12/23/20, at 1:36 p.m. family member (F)-A stated she saw R1 in a video chat on 12/9/20, and described R1 had "a very dry mouth and lips sticking together." F-A stated she spoke with an unidentified staff member at the facility who encouraged her to take the facility provided essential caregiver class so that F-A could visit R1. F-A took the class on 12/12/20. On 12/14/20, F-A was informed of R1's poor intake and was encouraged to visit R1 for dinner on that day to see if F-A could get R1 to eat. F-A stated she arrived at the facility at about 5:15 p.m. and attempted to assist R1 with the dinner meal. F-A stated the food and beverage

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F 692	Continued From page 6	F 692		

fell out of R1's mouth. F-A never saw R1 swallow anything that visit. F-A described R1 as "totally unresponsive" and with a "very dry mouth." F-A stated when registered nurse (RN)-A came in and saw R1, RN-A seemed surprised at R1's condition and said R1 was not like this the last time she worked with her on 12/11/20. RN-A obtained a set of vital signs and R1's O2 sats (blood oxygen level) were 65%. RN-A then placed oxygen on R1. A decision was made to send R1 to the hospital and 911 was called. F-A stated paramedics told her R1 probably would not have made it through the night if R1 did not go to the hospital when she did. F-A stated R1's condition was because she did not eat or drink. F-A further stated that either she or other family members had called the facility two times a day throughout R1's admission for updates and were not told R1 was not eating or drinking.

Several attempts made to contact RN-A for interview were unsuccessful.

When interviewed on 12/24/20, at 9:13 a.m. registered dietician (RD) stated she was unable to see R1 in person before R1 left the facility on 12/14/20. RD stated that she reviewed R1's progress notes to complete the admission assessment. RD stated she must have missed the notes that indicated R1 had not taken medications due to not being able swallow. RD further stated not notified that R1 did not take the ordered nutrition supplement and that "in a perfect world" she would expect to be notified of intake concerns from staff as soon as they were identified but admitted that notification did not always happen right away.

During interview on 12/28/20, at 8:45 a.m. RN-B

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F 692	Continued From page 7	F 692		

remembered R1 did not eat or drink and would not even open her mouth. "When I came [to work 12/6/20] the report I got said she don't [sic] eat she don't [sic] drink. When I tried to give her medication she would not open her mouth and would not respond to conversation." RN-B stated the normal process would be to notify the RD, the provider and speech therapy when a resident was not eating. RN-B stated she did not notify anyone because she thought everyone was already aware. RN-B stated the nursing assistants (NAs) document the resident's intake into the electronic health record (EHR) and the nurses were supposed to assess the resident and review the resident's intake.

When interviewed on 12/28/20, at 9:39 a.m. RN-C stated that speech therapy was in house and they typically see a resident within 24 hours of admission. "Even through Covid all therapy and nutrition assessments were being done in a reasonable amount of time." RN-C stated that upon admission R1 had difficulty to swallow and refused food. RN-C further stated the speech therapist (ST) and RD should be notified when someone did not eat. RN-C verified R1 had an order for speech therapy evaluation and treatment dated 12/4/20, and could not explain why R1 did not receive that evaluation. RN-C further confirmed R1's nutrition assessment indicated R1 did not have any difficulty to swallow. RN-C stated the RD was supposed to complete an in-person assessment with the resident and would contact the family if the resident was unable to communicate. RN-C stated the nurse should notify dietary and the nurse practitioner (NP) when intake concerns were identified. RN-C further stated R1 was admitted to the hospital on 12/14/20, for

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	245055	A. BUILDING _____ B. WING _____	C 12/28/2020

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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F 692	Continued From page 8	F 692		

intravenous fluid administration and an elevated Creatinine level. RN-C further stated, "Elevated Creatinine indicates dehydration."

Several attempts to contact the nurse practitioner (NP-A) who cared for R1 were unsuccessful.

When interviewed on 12/28/20, at 11:05 a.m. ST stated she did not see R1 and could not explain why she was not notified of the speech evaluation order. ST stated that Monday through Friday, the clinical coordinators notify ST of any new orders for speech or swallow therapy. ST further stated she always enters a progress note into the EHR when she saw a resident and verified there was no progress note from her in R1's chart. While reviewing R1's EHR, ST stated she would have definitely seen R1 as the progress notes indicated concerns when R1 swallowed.

Attempt to contact the clinical coordinators were unsuccessful and therefore, they were unavailable for interview.

When interviewed on 12/28/20, at 11:21 a.m. dietary technician (DT) stated that she would complete the initial resident nutrition assessment within the first three days of admission. DT stated "I usually go and see the resident and if they are not going to be able to communicate, then I call the family." DT could not recall if R1 was seen but did talk to R1's family member. DT verified completion of the initial nutrition screen for R1 on 12/7/20. "I just went by the chart and then talked to the family. I looked at the chart and did not see the 'can't swallow' documented on 12/6/20." DT stated she would have contacted speech therapy had she seen that. "I did take the poor appetite into consideration and that is why we

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F 692	Continued From page 9	F 692		

started her on the HNS." DT stated, "The RD was supposed to see the resident and do a complete admission nutrition assessment within five days of the initial nutrition screen which would have been 12/12/20, for R1. "The RD should first attempt to visit [the resident] and then communicate with family."

When interviewed on 12/28/20, at 2:47 p.m. assistant director of nursing (ADON) stated the RD or DT would do a nutritional assessment on all residents within 3 business days from admission. ADON stated the assessment should be done in person if resident was able to communicate, otherwise they rely on staff and family interviews. The clinical managers were supposed to run a report and review all progress notes for the previous 24 hours. Any concerns noted from the report or notes should have been discussed in the daily (M-F) clinical meeting in which dietary was always present. ADON further stated any swallowing concerns should have been discussed in the unit IDT (interdisciplinary team) meetings as well. ADON verified R1's nutritional assessment dated 12/7/20, did not indicate any swallowing concerns.

R1's hospital admission note dated 12/14/20, indicated R1's admission diagnoses included severe sepsis, pneumonia, dehydration and acute kidney injury. R1's Creatinine was 3.25 mg/dl (milligrams per deciliter) (normal Creatinine range would be 0.6 to 1.2 mg/dl).

R1's speech therapy hospital inpatient progress note dated 12/23/30 indicated, R1's lack of oral intake was "not only related to refusals/her cognitive status but also related to the swallow function alone - pt's physical oral motor abilities

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do not allow her to manipulate food or liquid or trigger any functional swallow." A clinical swallow evaluation dated 12/17/20, indicated speech therapy would follow R1 daily and attempt oral intake trials as able.

The facility policy Nutrition Assessments last revised 12/31/18, identified a comprehensive nutritional assessment was to be used to evaluate nutrition and hydration risks. Within three business days of admission, an RD or DT must complete an Initial Nutrition Interview/Screen. The RD should complete a Nutrition Assessment upon admission using "direct observation of and communication with the resident, other potential resources, licensed and non-licensed staff [all shifts] physician, family members, or external consultants as appropriate and review of the clinical record."

The undated facility process Scheduling Steps instructed the clinical coordination staff to check the EHR for therapy orders and outlined a step by step process on how to search for therapy orders in the EHR. The process further instructed staff to assign a resident to a therapist's caseload and then print the individual therapists' schedules with key points such as evaluations highlighted.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 5, 2021

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

Re: Reinspection Results
Event ID: HWDV12

Dear Administrator:

On January 25, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 7, 2020. At this time these correction orders were found corrected.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 12, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: HWDV11

Dear Administrator:

The above facility was surveyed on December 23, 2020 through December 28, 2020 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:

Sarah Grebenc, Unit Supervisor
Metro B 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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
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WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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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 12/23/20 through 12/28/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H 5055264 C/MN68329 with a licensing order issued. The following complaint was found to be UNSUBSTANTIATED: H5055265C/MN68399 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement an ordered swallow evaluation/assessment which resulted in a	2 945	Correction date on or before January 20, 2021.	1/20/21

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2 945	Continued From page 2	2 945		

decline of nutrition and hydration status for 1 of 3 residents (R1) reviewed for nutrition and hydration. This resulted in actual harm when R1 was admitted to the hospital with sepsis, pneumonia and dehydration that required intravenous hydration and nutrition therapy.

Findings include:

R1 was admitted to the facility on 12/4/20. R1's pre-admission history and physical progress notes indicated R1 had not been eating, drinking or taking medications. R1 had received palliative care and hospice evaluations but R1's family declined hospice care.

R1's admission Minimum Data Set (MDS) dated, 12/10/20, identified R1 with severe cognitive impairment and required extensive assistance with eating. The MDS indicated no signs or symptoms of possible swallowing disorder. R1's diagnosis included non-Alzheimer's dementia, metabolic encephalopathy (a problem in the brain caused by chemical imbalance in the blood) and renal insufficiency (a condition in which the kidneys lose ability to remove waste).

R1's nutritional assessment dated 12/7/20, identified R1 required a regular diet with regular textures and thin liquids. The assessment further identified R1 was completely dependent on staff to eat and had no difficulties with chewing or swallowing. The nutritional assessment was completed by the dietary technician (DT) who reviewed progress notes and spoke with R1's family. The nutritional assessment did not include any meal or intake observations of R1 by the DT or registered dietician (RD).

R1's care plan initiated 12/4/20, identified R1 had

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2 945	Continued From page 3	2 945		

a nutritional problem or potential nutritional problem and instructed staff to monitor, document and report any signs or symptoms of dysphagia (difficulty swallowing) or refusal to eat. Care plan further instructed registered dietician to evaluate and make diet change recommendations as needed.

R1's physician order dated 12/4/20, indicated, "SLP: Eval and Tx [speech-language-pathologist to evaluate and treat]."

R1's physician order dated 12/7/20, indicated, "Provide 120 cc [cubic centimeters] HNS [house nutrition supplement] TID [three times a day]. Document [percent] intake. Notify RD [registered dietician] if pt. refuses [times] 3."

R1's progress notes dated 12/6/20, at 8:59 a.m. indicated R1 did not receive ordered medication because she "can't swallow" and "pushed and throws away food or med."

R1's progress note dated 12/7/20, at 3:09 p.m. indicated, "Patient only taking a few bites at breakfast. Will spit out food and clench teeth together at times. Consumed 100 cc of ice cream and drank 60 cc of fluids...Call received and spoke with [R1's family member/F-A]. Updated on intake...Refusing to take medications. [F-A] stated patient likes ice cream and will only take a few bites at a time and then come back for more a while later. NP [nurse practitioner] here and updated on status. See new orders." R1's physician order for HNS was changed to magic cup (a nutritional supplement similar to ice cream in flavor and texture).

R1's progress notes dated 12/8/20, at 2:00 p.m. indicated, "Patient only taking a few bites at

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2 945	Continued From page 4 meals." R1's progress notes dated 12/9/20, at 1:17 p.m. indicated, "Patient only taking a few bites at meals." R1's progress note dated 12/10/20, at 9:12 p.m. indicated, "She has not been eating well, unable to open mouth, clinched her teeth during meals or pushing away staff hand when been [sic] fed. Exhibited the same behavior with med intake." R1's progress note dated 12/11/20, at 1:40 p.m. indicated, "Pt has poor diet intake." R1's progress note dated 12/12/20, at 8:43 p.m. indicated, "She refused both meds and meals-unable to open mouth, clinched her teeth during meals or pushing away staff hand when been [sic] fed." R1's progress note late entry dated 12/14/20, at 9:47 a.m. indicated nurse practitioner was updated on "patient not eating and only taking sips of fluids." R1's progress note dated 12/14/20, at 8:20 p.m. indicated "writer went to take pt her medication and she noted that pt was unable to swallow and that pt was not responding to verbal stimuli. Pt was not opening her eyes and periodically pt's arms and body will shake. Pt had shallow breathing RR [respiratory rate] 28 B/P [blood pressure] 103/63 P [pulse] 89 Oxygen 62-75% on RA [room air]. Oxygen administration was initiated and pt's oxygen came up to 95% on 2L NC [nasal cannula]. Writer updated [F-A] who was present in the room about her mom's status and she stated," I want to give her a fighting chance and stated that she is not ready for	2 945		

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comfort cares." [F-A] was also on the phone with [F-B] who also indicated that they want immediate interventions and that they wanted their mother to be seen physically by the doctor. Writer paged on call...and was updated of the pt's status and pt's family wishes and she stated to send pt to the ER at 1857 [6:57 p.m.]... Emergency services were called... Pt left the facility at 1923 [7:23 p.m.] on a stretcher with the EMT [for the hospital]."

R1's Nutrition Amount Eaten record for 12/5/20 through 12/13/20, indicated R1 ate 0-25% of meal 17 times, 26-50% of meal 1 time, 51-75% of meal one time and refused four times. R1's Nutrition Amount Drank record indicated R1 had no fluid intake on two days and 120 cc or less on four days. The remaining three days, R1's record indicated R1 consumed 720 cc, 300 cc and 150 cc.

When interviewed on 12/23/20, at 1:36 p.m. family member (F)-A stated she saw R1 in a video chat on 12/9/20, and described R1 had "a very dry mouth and lips sticking together." F-A stated she spoke with an unidentified staff member at the facility who encouraged her to take the facility provided essential caregiver class so that F-A could visit R1. F-A took the class on 12/12/20. On 12/14/20, F-A was informed of R1's poor intake and was encouraged to visit R1 for dinner on that day to see if F-A could get R1 to eat. F-A stated she arrived at the facility at about 5:15 p.m. and attempted to assist R1 with the dinner meal. F-A stated the food and beverage fell out of R1's mouth. F-A never saw R1 swallow anything that visit. F-A described R1 as "totally unresponsive" and with a "very dry mouth." F-A stated when registered nurse (RN)-A came in and saw R1, RN-A seemed surprised at R1's condition and said R1 was not like this the last

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2 945	Continued From page 6	2 945		

time she worked with her on 12/11/20. RN-A obtained a set of vital signs and R1's O2 sats (blood oxygen level) were 65%. RN-A then placed oxygen on R1. A decision was made to send R1 to the hospital and 911 was called. F-A stated paramedics told her R1 probably would not have made it through the night if R1 did not go to the hospital when she did. F-A stated R1's condition was because she did not eat or drink. F-A further stated that either she or other family members had called the facility two times a day throughout R1's admission for updates and were not told R1 was not eating or drinking.

Several attempts made to contact RN-A for interview were unsuccessful.

When interviewed on 12/24/20, at 9:13 a.m. registered dietician (RD) stated she was unable to see R1 in person before R1 left the facility on 12/14/20. RD stated that she reviewed R1's progress notes to complete the admission assessment. RD stated she must have missed the notes that indicated R1 had not taken medications due to not being able swallow. RD further stated not notified that R1 did not take the ordered nutrition supplement and that "in a perfect world" she would expect to be notified of intake concerns from staff as soon as they were identified but admitted that notification did not always happen right away.

During interview on 12/28/20, at 8:45 a.m. RN-B remembered R1 did not eat or drink and would not even open her mouth. "When I came [to work 12/6/20] the report I got said she don't [sic] eat she don't [sic] drink. When I tried to give her medication she would not open her mouth and would not respond to conversation." RN-B stated the normal process would be to notify the RD, the

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 12/28/2020

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) COMPLETE DATE
2 945	Continued From page 7	2 945		

provider and speech therapy when a resident was not eating. RN-B stated she did not notify anyone because she thought everyone was already aware. RN-B stated the nursing assistants (NAs) document the resident's intake into the electronic health record (EHR) and the nurses were supposed to assess the resident and review the resident's intake.

When interviewed on 12/28/20, at 9:39 a.m. RN-C stated that speech therapy was in house and they typically see a resident within 24 hours of admission. "Even through Covid all therapy and nutrition assessments were being done in a reasonable amount of time." RN-C stated that upon admission R1 had difficulty to swallow and refused food. RN-C further stated the speech therapist (ST) and RD should be notified when someone did not eat. RN-C verified R1 had an order for speech therapy evaluation and treatment dated 12/4/20, and could not explain why R1 did not receive that evaluation. RN-C further confirmed R1's nutrition assessment indicated R1 did not have any difficulty to swallow. RN-C stated the RD was supposed to complete an in-person assessment with the resident and would contact the family if the resident was unable to communicate. RN-C stated the nurse should notify dietary and the nurse practitioner (NP) when intake concerns were identified. RN-C further stated R1 was admitted to the hospital on 12/14/20, for intravenous fluid administration and an elevated Creatinine level. RN-C further stated, "Elevated Creatinine indicates dehydration."

Several attempts to contact the nurse practitioner (NP-A) who cared for R1 were unsuccessful.

When interviewed on 12/28/20, at 11:05 a.m. ST

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2 945	Continued From page 8	2 945		

stated she did not see R1 and could not explain why she was not notified of the speech evaluation order. ST stated that Monday through Friday, the clinical coordinators notify ST of any new orders for speech or swallow therapy. ST further stated she always enters a progress note into the EHR when she saw a resident and verified there was no progress note from her in R1's chart. While reviewing R1's EHR, ST stated she would have definitely seen R1 as the progress notes indicated concerns when R1 swallowed.

Attempt to contact the clinical coordinators were unsuccessful and therefore, they were unavailable for interview.

When interviewed on 12/28/20, at 11:21 a.m. dietary technician (DT) stated that she would complete the initial resident nutrition assessment within the first three days of admission. DT stated "I usually go and see the resident and if they are not going to be able to communicate, then I call the family." DT could not recall if R1 was seen but did talk to R1's family member. DT verified completion of the initial nutrition screen for R1 on 12/7/20. "I just went by the chart and then talked to the family. I looked at the chart and did not see the 'can't swallow' documented on 12/6/20." DT stated she would have contacted speech therapy had she seen that. "I did take the poor appetite into consideration and that is why we started her on the HNS." DT stated, "The RD was supposed to see the resident and do a complete admission nutrition assessment within five days of the initial nutrition screen which would have been 12/12/20, for R1. "The RD should first attempt to visit [the resident] and then communicate with family."

When interviewed on 12/28/20, at 2:47 p.m.

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2 945	Continued From page 9	2 945		

assistant director of nursing (ADON) stated the RD or DT would do a nutritional assessment on all residents within 3 business days from admission. ADON stated the assessment should be done in person if resident was able to communicate, otherwise they rely on staff and family interviews. The clinical managers were supposed to run a report and review all progress notes for the previous 24 hours. Any concerns noted from the report or notes should have been discussed in the daily (M-F) clinical meeting in which dietary was always present. ADON further stated any swallowing concerns should have been discussed in the unit IDT (interdisciplinary team) meetings as well. ADON verified R1's nutritional assessment dated 12/7/20, did not indicate any swallowing concerns.

R1's hospital admission note dated 12/14/20, indicated R1's admission diagnoses included severe sepsis, pneumonia, dehydration and acute kidney injury. R1's Creatinine was 3.25 mg/dl (milligrams per deciliter) (normal Creatinine range would be 0.6 to 1.2 mg/dl).

R1's speech therapy hospital inpatient progress note dated 12/23/30 indicated, R1's lack of oral intake was "not only related to refusals/her cognitive status but also related to the swallow function alone - pt's physical oral motor abilities do not allow her to manipulate food or liquid or trigger any functional swallow." A clinical swallow evaluation dated 12/17/20, indicated speech therapy would follow R1 daily and attempt oral intake trials as able.

The facility policy Nutrition Assessments last revised 12/31/18, identified a comprehensive nutritional assessment was to be used to evaluate nutrition and hydration risks. Within

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2 945	Continued From page 10 three business days of admission, an RD or DT must complete an Initial Nutrition Interview/Screen. The RD should complete a Nutrition Assessment upon admission using "direct observation of and communication with the resident, other potential resources, licensed and non-licensed staff [all shifts] physician, family members, or external consultants as appropriate and review of the clinical record." The undated facility process Scheduling Steps instructed the clinical coordination staff to check the EHR for therapy orders and outlined a step by step process on how to search for therapy orders in the EHR. The process further instructed staff to assign a resident to a therapist's caseload and then print the individual therapists' schedules with key points such as evaluations highlighted. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods and fluids given, offered, or consumed by residents reflect the nutritional needs to prevent nutritional decline and dehydration. The facility could ensure swallow evaluations, when ordered, as completed per physician order. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI). The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		