

Protecting, Maintaining and Improving the Health of All Minnesotans

**Electronically Delivered** 

January 14, 2022

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

RE: CCN: 245618 Survey Cycle Start Date: January 11, 2022

Dear Administrator:

On January 11, 2022 a survey was completed at your facility by the Minnesota Department of Health to investigate complaints 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. At the time of survey, the complaints were found to be both unsubstantiated and substantiated. However, the facility was found to be in compliance because corrective action was taken prior to the on-site investigation. Therefore, at the time of the investigation, the facility was found to meet federal requirements. A plan of correction is not required.

Also at the time of this survey, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute § 144.653 and/or Minnesota Statute § 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to federal deficiencies only.

Electronically attached is your copy of the Federal CMS-2567 Form and State Form.

Feel free to contact me if you have questions.

Sincerely,

Kumala Piske 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE         DATE           F 000         INITIAL COMMENTS         F 000         F 000         On 1/11/2022, a standard abbreviated survey was completed at your facility to conduct a compliant investigation. Your facility us found to be IN compliant ewents for Long Term Care Facilities.         F 000         F 000         INITIAL COMMENTS         F 000           The following complaints were found to be UNSUBSTANTIATED. H5618022C (MN70036). The following complaints were found to be SUBSTANTIATED. H5618022C (MN70036). The following complaints were cited due to actions taken by the facility prior to the survey.         The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       COMPLETED         ANDE OF PROVIDER OR SUPPLIER       245618       STREET ADDRESS, CITY, STATE, ZIP CODE       COMPLETED         WALKER METHODIST WESTWOOD RIDGE II       STREET ADDRESS, CITY, STATE, ZIP CODE       STREET ADDRESS, CITY, STATE, ZIP CODE       COMPLETED         PRETRY       SUMMARY STATEMENT OF DEFICIENCIES       STREET ADDRESS PLAN OF CORRECTION SHOLD BE       COMPLETED         PRETRY       REGULATORY OR ISC IDENTIFYING INFORMATION)       TAG       PRETRY       CRCH CORRECTION SHOLD BE         PRETRY       REGULATORY OR ISC IDENTIFYING INFORMATION)       TAG       PRETRY       CRCH CORRECTION SHOLD BE         F 000       INITIAL COMMENTS       F 000       F 000       F 000       F 000         F 1000       INITIAL COMMENTS       F 000       F 000       F 000       F 000         F 1000       INITIAL COMMENTS       F 000       <	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
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Mail Method         Submatry Statement of DEFIDENCES         Description         PROVIDERS PLAN OF CORRECTION         Owner of Correction	WALKER		WOOD RIDGE II					
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On 1/11/2022, a standard abbreviated survey was completed at your facility to conduct a compliaint investigation. Your facility was found to be IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5618022C (MN70036). The following complaints were found to be SUBSTANTIATED: H5618023C (MN8395), however NO deficiencies were cited due to actions taken by the facility prior to the survey. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
<ul> <li>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.</li> <li>The following complaints were found to be UNSUBSTANTIATED: H5618022C (MN70036). The following complaints were found to be SUBSTANTIATED: H5618023C (MN86395), however NO deficiencies were cited due to actions taken by the facility prior to the survey.</li> <li>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.</li> </ul>	F 000	INITIAL COMMEN	rs	F 0	000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		was completed at y complaint investigat be IN compliance w Requirements for L The following comp UNSUBSTANTIATED: however NO deficies actions taken by the The facility is enroll signature is not req page of the CMS-2 correction is require	rour facility to conduct a tion. Your facility was found to with 42 CFR Part 483, ong Term Care Facilities. blaints were found to be ED: H5618022C (MN70036). blaints were found to be H5618023C (MN68395), encies were cited due to e facility prior to the survey. ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, the facility must					

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.

PRINTED: 01/14/2022

Minneso	Minnesota Department of Health							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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	*****ATTENTION******							
	NH LICENSING CORRECTION ORDER							
	144A.10, this correct pursuant to a surver found that the defice herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been						
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.						
	at your facility by su Department of Hea	FS: mplaint survey was conducted rveyors from the Minnesota lth (MDH). Your facility was se with the MN State						
Vinnesota D	The following comp	laint was found to be						

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

TITLE

(X6) DATE

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## PRINTED: 01/14/2022 FORM APPROVED

Minnesc	Minnesota Department of Health							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
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