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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QW3P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 27996

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245618**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER METHODIST WESTWOOD RIDGE II**
(L4) **61 THOMPSON AVENUE WEST**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/12/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **04** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **37** (L18)
13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
37				
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susie Haben, Unit Supervisor 12/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 12/21/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/21/2012
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 13, 2018

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

RE: Project Number S5618007

Dear Administrator:

On November 5, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 18, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 3, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 18, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 27, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 18, 2018, effective November 27, 2018 and therefore remedies outlined in our letter to you dated November 5, 2018, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
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

CMS Certification Number (CCN): 245618

December 13, 2018

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 27, 2018 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QW3P

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(L3) **WALKER METHODIST WESTWOOD RIDGE II**
(L4) **61 THOMPSON AVENUE WEST**
(L5) **WEST SAINT PAUL, MN** (L6) **55118**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/18/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **04** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

12.Total Facility Beds **37** (L18)
13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
37				
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Mary Heim, HFE NE II — 11/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Sr. Health Program Rep — 12/20/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/21/2012
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 5, 2018

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

RE: Project Number S5618007

Dear Administrator:

On October 18, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is November 27, 2018.

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.

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 18, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 18, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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
	245618	A. BUILDING _____ B. WING _____	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(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 survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/15/18 through 10/18/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 10/15/18 through 10/18/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. 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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		11/27/18

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

Electronically Signed | 11/15/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(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 655	Continued From page 1 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the	F 655	Walker Methodist Westwood Ridge II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(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 655	Continued From page 2 facility failed to ensure Baseline Care Plan was developed to include all pertinent information within 48 hours of admission, and orders were followed for 1 of 2 residents (R26) reviewed for hospitalizations, when R26 had orders to be non-weight bearing and wear a knee immobilizer at all times, and staff were noted to remove the brace intermittently and transfer R26 without the immobilizer. Findings include: Review of a face sheet revealed R26 admitted to the facility 8/30/18, with diagnosis of a displaced comminuted fracture of the right tibia (shin bone) and fibula (calf bone). Review of the hospital discharge orders faxed to the facility on 8/30/18, revealed R26 was ordered to be non-weight bearing on the right lower extremity. Additionally, there was an order regarding bracing that instructed R26 to wear the "Knee immobilizer to right leg at all times, no [range of motion] of the right knee. Ok to open at rest to ice and for skin checks." R26 was ordered to follow up with an orthopedic appointment in one week. Review of orders in the electronic medical record revealed an order dated 8/30/18, for "Knee immobilizer to [right] leg at all times, no [range of motion] of the [right] knee. Ok to open at rest to ice and for skin checks." Review of the care plan revealed the following: R26 was noted to have a right tibia fracture, and listed as non-weight bearing to the right lower extremity upon admit, 8/30/18. The requirement for the "immobilizer on at all times" was written in the care plan on 9/11/2018. A focus of the care plan titled "The resident has an alteration in	F 655	provides innovative, technically competent, effective, sensitive, individualized, person-centered care and programs. We value the dignity and uniqueness of each individual and strive to maintain their autonomy and independence while providing a safe and secure environment. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest of Facility, its Administrator or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within 10 days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare program. R26 discharged from the facility on 9/27/18. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. BUILDING _____ B. WING _____	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

(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 655	Continued From page 3 musculoskeletal status [related to] fracture of the [right tibia/fibula]" was not initiated until 9/19/18. This section detailed the supportive brace, and referred to both doctor orders for weight bearing status, and the physical therapy treatment plan. Review of Provider Progress Notes revealed the nurse practitioner (NP) visited R26 in the facility the day after admission on 8/31/18. The notes explained that R26 fell at home, developed knee pain, and was found to have a fractured fibula and tibia. After orthopedic consult, nonsurgical treatment was recommend, and R26 was made non-weight bearing in the right lower extremity, with a knee immobilizer. R26 admitted to the facility for further rehab. At the time of this NP visit, R26 stated having no pain, but having some minor pain at times, however explained not having a lot of pain related to the injury. The NP's assessment/plan after this visit was to continue non-surgical treatment, non-weight bearing on the right lower extremity and knee immobilizer; follow up with orthopedic specialist in one week; schedule Tylenol 650 milligrams three times daily, and every eight hours as needed and ice the area three times a day and as needed. Review of Provider Progress Notes revealed the medical doctor (MD) visited R26 on 9/6/18. The MD also noted that R26 had been seen by an orthopedic specialist who recommended non-surgical management with immobilizer for 24 hours per day, and non-weight bearing status. A Provider Progress Note dated 9/7/18, revealed the NP visited R26 who had right leg pain at times, like the muscles were tightening around the broken bones. R26 described the pain as severe enough to wake her up while sleeping. Per	F 655	1) Whole house audit will be completed to ensure baseline care plans reflect current weight bearing status of residents, including any supportive devices. The baseline care plan will be completed through the admission assessment and physician orders. The supportive device and weight bearing order will be processed as a physician order, and documented by the licensed nurse on the electronic treatment record. The physician orders will flow to the care sheets for staff to follow. These are updated as physician orders change related to weight bearing status and supportive device use. 2) Audits will be completed of each new admission to ensure baseline care plans reflect current weight bearing status of residents, including any supportive devices, to ensure accuracy with physician orders. Any discrepancies will be corrected immediately. Residents that have a specific weight bearing or supportive device order will be monitored until discharge to ensure any changes are processed appropriately. 3) Supportive device application and weight bearing status will be monitored by licensed staff daily to ensure the resident's supportive device is being utilized and weight bearing status is being followed as ordered by physician. 4) Nursing staff will be educated on the facility policy for Baseline Care Plans,	

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F 655	Continued From page 4 the progress note, during the exam the NP noted R26's immobilizer was off. When asked about this, R26 reported the "immobilizer was taken off yesterday and no one put it back on. [R26] guessed [R26] didn't need to wear it anymore. [R26] thinks the staff was tired of taking off and putting back on. Educated [R26] needs to have this on at all times as [R26] has an unstable fracture and [R26's] fracture will not heal without keeping it in place. Requested nursing staff to put back on immediately, discussed with nurse manager notifying [orthopedics] to see if need to perform [x-ray] today to monitor fracture healing. Therapy then came in to see [R26] and put immobilizer on [R26] and made sign for room that says immobilizer needs to be on at all times." The NP's assessment/plan after the visit noted non-surgical treatment, non-weight bearing, and the knee immobilizer. The NP noted, "Immobilizer taken off yesterday, unsure how long off and how many transfers. Patient and staff educated needs to be on at all times for unstable fracture. Requested nurse manager to call and update [orthopedics] and request if need to [x-ray]." A Provider Progress Note dated 9/11/18, revealed the NP visited R26, who reported having a lot of pain, and not feeling it was controlled with the Tylenol only. R26 reported having trouble sleeping the previous night from the pain, and mentioned the pain was unbearable at times. R26 had a wound on the back of the leg now, and thought it was from the brace. R26 reported "they have been taking [my] brace off especially at night." R26 said last night staff did take the brace off, and R26 did get up to the lounge in a chair for a while during the night. R26 did not recall the brace being on while R26 was transferred. NP noted that the wound nurse saw R26 yesterday	F 655	including following weight bearing status and supportive device orders, prior to our compliance date. On-call nursing staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 5) Random audits will be completed weekly to ensure staff are following weight bearing status orders and supportive devices are implemented as ordered. 6) Audits will be ongoing until reviewed at QAA monthly and a determination is made that they are no longer necessary.	

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F 655	Continued From page 5	F 655		

for the calf wound, and felt it was from the immobilizer so the wound nurse had entered an order in the electronic medical record for staff to remove the immobilizer at night when R26 was in bed. Per the provider progress note, nursing reported that the immobilizer was off during the night, and it was unclear whether it was on for transfers to the chair in the lounge or not. The NP noted that "[R26] has been complaining of a lot more pain recently since having the immobilizer off some. Discussed with both [R26] and nursing that there are no orders from providers to remove immobilizer and this needs to be kept on at all times except for basic hygiene once daily. Educated staff [R26] has unstable fracture. Ordered [x-ray] for today and asked nursing to update [orthopedics] today and send results of [x-rays] for their review to determine if fracture more dislocated or unstable." NP noted ordering a pad area around the wound to help with skin-breakdown, and changed the wound nurse's order so it was clear the immobilizer needed to be on at all times as previously ordered, except for hygiene.

Review of an x-ray report dated 9/12/18, revealed impacted fractures described by the radiologist as appearing recent without significant new bone formation, with moderate joint effusion (abnormal accumulation of fluid in or around a joint), and no dislocation. The radiologist also noted that there was a cast and brace device interfering with imaging. The x-ray images and report was faxed to the orthopedic specialist on 9/12/18.

Review of a visit note from the orthopedic specialist dated 9/19/18, revealed R26 was recommended to remain in the straight leg immobilizer full time and be complete non-weight

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F 655	Continued From page 6	F 655		

bearing on the right side. R26 was able to remove the immobilizer three times a day for hygiene and skin checks. X-rays were obtained and noted to be unchanged from prior x-rays on file.

A Provider Progress Note dated 9/20/18, revealed the NP visited R26. R26 reported seeing the orthopedic specialists yesterday who performed more x-rays, and wanted to follow-up with R26 next Wednesday. R26 thought she would remain unable to bear weight on the right leg for a while still. The NP's assessment/plan noted R26's pain was controlled with Tylenol and tramadol every six hours as needed, and the immobilizer was now being left on at all times. The NP noted the 9/12/18 x-ray taken at the facility and forwarded to the orthopedic specialist, showing impacted fracture of proximal tibia and fibula, with moderate joint effusion (abnormal accumulation of fluid in or around a joint).

Review of a visit note from the orthopedic specialist dated 9/26/18, revealed R26's fracture was "significantly collapsed" and the overall alignment was not adequate. The distal portion of the fracture was in contact with the joint surface which could continue to erode. "If it heals as is, the knee may be unstable/non-functional and require further surgeries." The specialist felt surgical intervention was needed to allow for adequate bone healing. The note continued to mention that R26 may have been inadvertently weight bearing somewhat, per family report. X-rays were taken and showed significant collapsing, with bone resting on the joint surface. Surgery was planned for Friday of that week.
In a Provider Progress Note dated 9/27/18, the NP documented that the orthopedic specialist planned to perform surgery tomorrow to repair

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F 655	Continued From page 7 R26's complicated tibia/fibula fracture. During interview on 10/18/18, at 12:20 p.m. registered nurse (RN)-A said if the staff had a question about how to use a device like the immobilizer, they can talk to therapy about it. RN-A continued that details like the schedule for a device should usually be in the treatment administration record for nurses to refer to, and should be listed in the Kardex which is a resource that the nursing assistants refer to for information about how to care for each individual resident. RN-A was unsure how to pull a Kardex report for R26, since R26 had discharged. On 10/18/18, at 1:09 p.m. the director of therapy (DOT) said the hospital discharge orders usually contain the schedule for wearing a device, like an immobilizer, or therapy can try to get therapy notes from the hospital to see how devices were used. The DOT reviewed R26's initial physical therapy evaluation after admit on 8/31/18, and was able to see they had directions for R26 to be non-weight bearing, with no range of motion to the right lower extremity, and wearing the immobilizer at all times. On 10/18/18, at 1:54 p.m. the interim director of nursing (IDON) confirmed there was an initial order in the electronic medical record upon admit to wear the immobilizer at all times. Review of the Baseline Care Plan policy created 11/28/17, revealed baseline care plans would be developed and implemented within 48 hours of admission, with instructions needed to provide effective care of the resident. According to the policy, a baseline care plan included but was not limited to, initial goals based on admission orders,	F 655		

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F 655	Continued From page 8 and physician orders.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to include the resident in the development of care planned interventions, and reassess the effectiveness of interventions, review and revise the resident care plan with	F 657	R2 discharged from the facility on 10/22/18. R2 readmitted to the facility on 10/27/18. R2 will be included in any fall interventions as needed.	11/27/18

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F 657	Continued From page 9 input from the resident, in order to meet the residents' individualized need for least restrictive interventions. This had the potential to affect 1 of 2 resident (R2) reviewed for fall interventions. Findings include: During interview on 10/16/18, at 9:14 a.m. R2 described having a fall from bed. R2 explained having a terrible dream, and trying to get away from what was in that dream, and in doing that R2 "slid off the bed." R2 said the ace bandage wraps on both feet allowed R2 to slide on the carpeting as he tried to get up but slid out of bed. R2 was not injured, but said the facility put a special mattress with raised edges (perimeter mattress) on the bed as an intervention to prevent future falls. The perimeter mattress was observed to have high ridges on the sides of the mattress down by R2's lower body, no ridge in the middle of the mattress, and the same high ridges on the sides of the mattress up by R2's upper body. R2 felt the facility put the perimeter mattress in place without talking to the resident about it first, and did not like the mattress because R2 said "I feel like I can't get out of bed by myself." During observation on 10/17/18, at 8:39 a.m. nursing assistant (NA)-B entered R2's room to assist in getting R2 out of bed and into a chair to eat breakfast. NA-B asked if R2 needed help to sit up at the edge of the bed, or if R2 wanted to try to sit unassisted. R2 requested help, and NA-B gently held R2's leg and guided it up and over the raised edge of the perimeter mattress. NA-B said to R2, "That bump doesn't help, does it?" R2 sat on the edge of the bed. A loud, piercing alarm beeped a series of notes, and NA-B removed a device from the bed. NA-B	F 657	Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) Whole house audit will be completed to ensure all fall interventions have been reviewed with the resident and/or responsible party and that all are in agreement with the safety plan. 2) All new falls will be reviewed weekly to ensure residents and/or responsible parties have been involved in decision-making regarding safety interventions. 3) The facility policy Incidents/Accidents □Resident will be reviewed and updated to include ensuring resident and/or responsible party are included in decisions regarding safety interventions, as well as ongoing review of interventions to determine if they are still appropriate. 4) Licensed staff will be educated on the facility policy Incident/Accidents □ Resident prior to our compliance date. On-call licensed staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 5) Audits will be conducted weekly of all current residents who have fallen to review if safety interventions are still appropriate. 6) Audits will be ongoing until reviewed at QAA monthly and a determination is made	

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F 657	Continued From page 10 explained that the device was an alarm, and explained to the surveyor, "[R2] doesn't like the alarm." NA-B continued to explain how R2 had been trying to get up out of bed unassisted and had been falling, so they put the alarms on. NA-B clarified that this was when R2 first came to the facility, but reassured the resident that "he's fine now, but we just keep the alarm on just in case." At 8:43 a.m. NA-B left the room for a minute. R2 was asked about the alarm and said, "I don't like it, but it's for me." When asked if the alarm sounded at night while R2 readjusted self in bed R2 replied, "No" and said the alarm was "so that I don't escape." When asked if R2 was trying to escape, R2 laughed and said, "Just the alarm." At 8:44 a.m. NA-B returned to the room to assist R2 into a wheelchair. NA-B placed a transfer belt around R2, brought a walker close, and raised the bed before assisting R2 to stand, pivot, and sit in the wheelchair. R2 readjusted self in the wheelchair seat, and another piercing sequence of beeps sounded. NA-B said to R2 about the alarm, "I'm sorry, but I have to put that on. I know you don't like it." NA-B left the room at 8:50 a.m. R2 thought that the facility maybe mentioned something about the alarms before putting them in place, but did not remember much. R2 said the alarm on the wheelchair sounded whenever the resident's bottom left the seat of the chair. When asked if R2 was afraid to move and set off the alarm, R2 said, "I just don't like the sound. But I suppose it is for my own good." R2 pointed to the perimeter mattress and mentioned again how it was difficult to get up around the perimeter. R2 described dreams that used to be so vivid, that R2 was delirious and trying to move, and get up while dreaming. R2 said the facility thought it could have been caused by a medication interaction, so they adjusted the medications, and	F 657	that they are no longer necessary.	

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R2 felt that improved the situation. R2 occasionally had a vivid dream now, but not as often as before.

During interview on 10/18/18, at 2:28 p.m. registered nurse (RN)-A said interventions put in place after a fall were dependent on the cause of the fall. For example, if someone was confused and did not remember to use a call light, then maybe they would try an alarm first. If someone was rolling off the bed, then maybe a perimeter mattress would help them feel where they were located in bed. RN-A also typically asked therapy for input, and collaborated with the director of nursing for interventions. RN-A said, "As you know, alarms don't prevent falls, but will alert staff that something is going on. We don't want someone on the floor for 30 minutes or an hour, so that will keep beeping and tell you something is going on." RN-A said staff have to constantly review interventions to see if it is something the resident still needs, and gave an example that someone with something more acute going on, like a urinary tract infection with confusion, may need an intervention such as an alarm in place for safety short-term, then later staff can remove the alarm when they don't need it. RN-A said interventions, like alarms should be discussed with the resident or the family if a resident is not able to participate in a decision like that. RN-A was not at the facility when the interventions were put in place for R2, but said if a resident did not want an intervention, they should be educated on the risks and benefits, but that was the resident's choice at their risk. RN-A said a conversation like this would be documented in a progress note, and continued that sometimes alarms can agitate residents more, and in that case, might not be appropriate. The goal was to try to use the least

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restrictive interventions possible. RN-A was not previously aware that R2 felt restrained in bed by the perimeter mattress.

During interview on 10/18/18, at 1:15 p.m. the director of therapy (DOT) reviewed the physical therapy (PT) discharge summary, dated 9/13/18. At the time of the PT discharge, R2 was able to transition from laying to sitting but required moderate to maximum assistance from staff. R2 was able to sit at the edge of the bed, and from there was able to stand with assistance anywhere from contact to minimum assistance. DOT explained that therapy was made aware of falls during rehab rounds, and said interventions often included perimeter mattress or alarms if the resident was impulsive. DOT encouraged therapy staff to keep in contact with the nurse managers if they saw interventions that were not safe or appropriate. After reviewing the PT discharge notes, the DOT did not feel R2 would be able to go from lying in bed to sitting on the edge of the bed independently. DOT had not heard anything about R2 feeling restrained, but felt that if R2 had communicated that feeling to therapy, they would have communicated that to the nurse managers for discussion.

On 10/18/18, at 2:14 p.m. the interim director of nursing (IDON) spoke generally about interventions, and how they should be reassessed to determine whether they were still needed by a resident. IDON was unable to give specifics about R2 since she was not here at the time the interventions were put in place, but wondered how the benefit of a perimeter mattress had been explained to R2. IDON would have hoped someone explained to R2 that the purpose of the mattress was not to keep R2 in bed. When

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discussing the alarms, IDON confirmed that "nobody likes the alarm noise."

Review of the most recent minimum data set assessment, dated 8/17/18, revealed R2 was assessed to be cognitively intact (brief interview for mental status score 15). Review of the diagnoses list revealed diagnoses including but not limited to edema (swelling caused by excess fluid), hip pain, and restless legs syndrome.

Review of incident reports revealed R2 had the following falls since admission on 7/23/18:

-7/30/18: R2 was found sitting on the floor next to the bed and recliner. R2 explained sleeping in the recliner, and trying to move before sliding down the recliner to the floor.

-8/19/18: R2 was yelling for help and was found on knees next to bed. R2 explained dreaming about being able to walk and wanting to get up, but slipping out of bed instead.

-8/22/18: R2 was found kneeled down on the side of the bed. R2 claimed trying to put feet on the floor, but it was slippery, so R2 slipped to the floor in the process.

-8/24/18: At approximately 3:00 a.m. R2 was found kneeling down next to the bed. R2 explained thinking he was getting out of the car, and then slid off the bed. At approximately 6:00 a.m. R2 fell off the bed again and was found on knees next to the bed. The bed alarm was on, but R2 was laying half way on top of the alarm, so it did not go off. R2 described seeing something beautiful out the window and wanting to get up to look at it. The blinds were closed.

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F 657	Continued From page 14 -9/1/18: R2 was found on the floor between the bed and window, with upper body still on the bed. R2 explained "I was told I could go to the bathroom by myself." Review of R2's care plan revealed the facility put bed and recliner alarms in place on 8/24/18, and also updated the care plan to show they placed a perimeter mattress on the bed on 8/24/18. The care plan showed R2's ability to participate in a transfer was improving, as R2 had previously needed a full body mechanical lift for transferring, but was able to use a standing lift as of 8/16/18, per the care plan. R2 then moved to a front wheeled walker with assist of two staff per the care plan update on 8/29/18. On 9/11/18, the care plan was updated again to show R2 needed a front wheeled walker and assist of only one staff to transfer. Review of provider progress notes revealed a provider visit on 8/30/18, where the provider mentioned how Seroquel (an antipsychotic medication) was used to try to decrease R2's vivid dreams at night. The provider noted R2's confusion at night to be improved with the Seroquel. During a 9/4/18 provider visit, R2 reported having a fall over the weekend because of another dream. According to the visit note, R2 felt better recently, but then for some reason had another dream and tried to get up out of bed without help and fell. The provider noted that the dreams improved on Seroquel, and increased the dose due to the recent fall. A provider progress note from a visit on 9/6/18 noted that R2 mentioned his dreams had gone away now with the increased dose of Seroquel, and that he was sleeping restfully at night. A provider progress	F 657		

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	245618	A. BUILDING _____ B. WING _____	10/18/2018

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WALKER METHODIST WESTWOOD RIDGE II	61 THOMPSON AVENUE WEST WEST SAINT PAUL, MN 55118

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F 657	Continued From page 15	F 657		

note on 9/25/18 again noted that R2 was sleeping well and not having any vivid dreams or recent falls. A provider progress note on 9/27/18 noted that R2 had not had any further falls or dreams since the Seroquel dose had been increased. The provider also wrote that R2 had wondered whether he still has to sleep on the special air mattress with the raised edges because it was harder for him to get out of.

Review of the assessments and progress notes during the survey failed to provide documented evidence that R2 was involved in the decision to use the perimeter mattress or bed and chair alarms. Additionally, review failed to provide evidence that the alarms and perimeter mattress were reassessed to determine if they were still needed as time progressed, and after R2's condition changed and he was not having as continued vivid dreams.

During interview on 10/18/18, at 3:27 p.m. the IDON mentioned talking to a nurse manager, who could not remember if R2 was involved in a conversation about the perimeter mattress or alarms. IDON found progress notes documenting that the family was notified of R2's falls, but could not find documentation that R2 was spoken to about the alarm and mattress interventions, or involved in the decision to use the interventions.

The Incidents/Accidents policy and procedure, last revised 5/11/17, included the requirement to document any immediate interventions implemented after an incident, and then review and update safety interventions in the resident's care plan, and on the nursing assistant Kardex. The assigned nurse manager was responsible for reviewing the incident and circumstances

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F 657	Continued From page 16 surrounding the incident with the interdisciplinary team, and then identifying and implementing any recommended interventions. Data and information surrounding accidents/incidents was to be reviewed at the community's "QA&A committee." The procedure did not include any guidance for when or how to review interventions for continued effectiveness, and ongoing need. In a follow-up email sent 10/18/18, at 5:09 p.m. the administrator wrote that the facility treated this as a grievance as R2's concerns were previously unknown to the facility. After meeting with R2, the alarms were removed per resident choice, but the perimeter mattress would stay in place. RN-A followed up with R2's family who confirmed they were notified of the interventions at the time of the falls, and were in agreement with the plan. R2 noted that he was delusional at the time, and did not remember why the interventions were put in place at the time of the falls. The administrator wrote that all were in agreement of the current plan, and the care plan had been updated. An attached progress note from 10/18/18, confirmed R2 wanted the alarms removed as soon as possible, but wanted to keep the perimeter mattress, as R2 was discharging soon.	F 657		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		11/27/18

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F 880	Continued From page 17 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 18 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain infection control practices when they failed to empty existing urine and store a urine collection bag for 1 of 1 residents (R280) reviewed for a urinary catheter. Findings include: R280's Order Summary Report, printed on 10/16/18, indicated an active medical diagnosis that included benign prostatic hyperplasia with lower urinary tract symptoms (a condition in which the prostate enlarges and obstructs the flow of urine). R280's care plan, dated 10/4/18, indicated R280 had an indwelling Foley catheter. During an observation on 10/16/18, at 10:50 a.m.,	F 880	R280 discharged from the facility on 10/17/18. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) Whole house audit will be completed to determine which residents have catheters requiring emptying and storage of urine collection bag. 2) All new admissions will be audited weekly to determine which residents have catheters requiring emptying and storage of urine collection bag. 3) Nursing staff will be educated on the facility policy Catheter Care Indwelling prior to our compliance date. On-call	

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F 880	Continued From page 19 R280 was lying in bed in room. A urine drainage bag was hanging from the bed frame located to the left of the resident at the foot of the bed. The urine drainage tubing and bag was not connected to R280's catheter. The tubing was coiled with the end connection facing the ceiling over the bed linen. There was approximately 300 milliliters (mL) of dark amber urine in the urine collection bag and about 30 mL in the coiled tubing. On 10/16/18, at 10:30 a.m., nursing assistant (NA)-A entered R280's room. Resident 280 was brought to the hallway by NA-A, in a wheelchair, to be weighed. The urine drainage bag was not addressed. On 10/16/2018, at 12:10 p.m., NA-A transported R280 to the dining room from R280's room. The urine drainage bag was not addressed. On 10/16/18, at approximately 12:15 p.m., an interview was conducted with two family members (FM)-A and FM-B. FM-A verbalized that she found R280's urine collection bag laying on the floor and that they were concerned about a risk for infection. FM-A also verbalized that she found the urine drainage bag on the floor at approximately 11:15 a.m. and this has occurred on prior occasions. On 10/16/18, at 12:20 p.m., the urine drainage bag was observed to be hanging on a wastebasket located in R280's bathroom. The end of the drainage tubing was approximately 1 inch inside the wastebasket and directly in contact with the plastic bag located inside the waste basket. Several moistened brown tissues and a measuring graduate were located inside the wastebasket.	F 880	nursing staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 4) Random audits will be conducted weekly to ensure staff are following proper procedure for emptying and storage of urine collections bags. 5) Audits will be ongoing until reviewed at QAA monthly and a determination is made that they are no longer necessary.	

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F 880	Continued From page 20 On 10/16/18, at 12:29 a.m., registered nurse (RN)-A was interviewed. RN-A verbalized the standard is a urine catheter collection bag should be emptied when disconnected from a catheter. RN-A verbalized that there was approximately 280 mL of urine in the urine collection bag. RN-A then emptied the contents of the collection bag into the toilet in R280's bathroom. The urine collection bag was not discarded or cleaned by RN-A at this time. On 10/18/18 at 11:31 a.m., RN-A verbalized R280's urine collection bag and tubing was discarded because it was an infection control issue. R280's Clinical Physician Orders, printed on 10/16/18, indicated an order to the replace the urinary drainage and leg bag every two weeks written on 10/4/18. Document titled NAR Care Sheet, printed on 10/16/18, indicates R80's catheter was last changed on 10/2/18. The Facility's Catheter Care - Indwelling policy, dated 8/1/13, directed that care of a urinary catheter bag includes emptying drainage bag contents, rinsing the drainage bag, inside and out, with tepid water, and drying the outside of the drainage bag. The policy also directed that drainage bags should be replaced every two weeks.	F 880		

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K 000	INITIAL COMMENTS	K 000		

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE 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. OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to: FM.HC.Inspections@state.mn.us

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Walker Methodist Westwood Ridge II was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/15/2018

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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K 000	Continued From page 1 Code (LSC) Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Walker Methodist Westwood Ridge II is a 1-story building with no basement. The facility was constructed in 2012 and was determined to be of Type V(111) construction. The building is fully protected by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridors and is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 33 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been	K 354		11/27/18

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K 354	Continued From page 2 determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Sprinkler System - Out of Service This deficient practice could affect the safety of all (33) the residents with in the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 10/16/2018, observation and documentation reviewed revealed the following: The Facility does not have a current out of service policy for fire sprinkler systems. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 354	Policy titled Fire Alarm and Sprinkler Outage – Skilled was reviewed and updated. Director of Environmental Services or designee is responsible for correction and monitoring to prevent re-occurrence.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional	K 914		11/27/18

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K 914	Continued From page 3 testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99) Electrical Systems - Maintenance and Testing This deficient practice could affect the safety of all (33) the residents with in the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 10/16/2018, observation and documentation reviewed revealed the following: The Facility does not have a current electrical receptacle outlets test completed. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914	A facility audit will be completed of all resident rooms to test current electrical receptacle outlets. Documentation will be maintained noting test results including repairs or modifications needed, date completed, and room or area tested. This audit will be scheduled to be completed annually thereafter. Director of Environmental Services or designee is responsible for correction and monitoring to prevent re-occurrence.	
K 926 SS=C	Gas Equipment - Qualifications and Training CFR(s): NFPA 101	K 926		11/27/18

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K 926	Continued From page 4 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (11.5.2.1 (NFPA 99) Gas Equipment - Qualifications and Training of Personnel This deficient practice could affect the safety of all (33) the residents with in the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 10/16/2018, observation and documentation reviewed revealed the following: The Facility does not have a current med gas training policy. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 926	Policy titled Oxygen (O2) Administration – Skilled was reviewed and updated. All staff who handle medical gases and cylinders will be trained on policy including safety guidelines and usage requirements. Continuing education will be completed upon hire, and annually thereafter. Director of Nursing or designee is responsible for correction and monitoring to prevent re-occurrence.	