Electronically delivered
May 21, 2021

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

RE: CCN: 245055
Cycle Start Date: May 17, 2021

Dear Administrator:

On May 17, 2021, a 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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 an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- 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), 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, 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 August 17, 2021 (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 November 17, 2021 (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: 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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 05/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 05/17/2021, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5055282C (MN72415) with a deficiency cited at F561 and F656 The following complaint was found to be UNSUBSTANTIATED: H5055280C (MN72615/MN72763). No deficiency. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		6/3/21

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

Electronically Signed | 05/28/2021

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 561	Continued From page 1 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in a manner that promoted self determination for 1 of 3 (R2) reviewed for choices regarding undergarment attire. Findings include: R2's admission Minimum Data Set (MDS) dated 4/26/21, indicated R2 had a brief inventory of mental status (BIMS) score of 5, that indicated severe cognitive impairment and received total assistance from staff to dress and groom. The MDS identified medical diagnoses that included Alzheimer's disease and dementia in other	F 561	R1 was assisted in donning the preferred undergarment attire at the time of survey. R1□s Plan of Care was reviewed and revised as needed. All residents have the potential to be affected. Care Plans for residents potentially affected have been reviewed Facility policies on Resident Rights and Care Plans were reviewed. Licensed Nurses, Nursing Assistants and Occupational Therapists received education on following resident preferences as they are listed on the Care Plan/Kardex.	

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F 561	Continued From page 2 diseases with behavior disturbance. The MDS also indicated R2 to be diagonosed with end stage renal disease, neurogenic bladder (nervous system condition causing loss of bladder control) and obstructive uropathy (a condition where urine backs up into the kidneys). MDS indicated R2 was continent of bowel and occasionally incontinent of bladder. R2 has a suprapubic catheter (a catheter inserted into the stomach for elimination of urine). R2 had not rejected cares. R2's care plan dated 4/26/21, identified R2 needed total assistance of staff to dress and directed staff to assist with all grooming. Also noted on the care plan, family (F)-A, preferred R2 to wear underwear, not a disposable brief. During an interview on 5/17/21, at 10:39 a.m. nursing assistant (NA)-A reported she had dressed R2 that morning. NA-A reported she looked for a brief in the room and the licensed practical nurse (LPN)-A told NA-A to not put a brief on R2 per family. NA-A reported there was no underwear in the room for R2 and all clothes were in the laundry and did not put underwear or a disposable brief on R2, just pants. During an interview on 5/17/21, at 11:04 a.m. F-A arrived to facility on 5/17/21, at 10:11 am. R2 was done with breakfast and was in the community area with other residents. F-A indicated checking R2 and found he only wore pants and did not have any underwear on. F-A reported that at least 15 pair of underwear were brought to facility upon admission of 4/26/21, and have always been in R2's drawer in the room. F-A proceeded to show the top dresser drawer full of underwear clean and folded. F-A reported R2 was either put in a disposable brief or pants	F 561	Monitoring of compliance will be done through weekly facility audits on Implementation of Care Planned Interventions Interim DON or designee will be responsible. The facility will review audit results at monthly QA/QAPI meetings and make recommendations as indicated. This deficiency will be corrected by 6/3/21.	

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F 561	Continued From page 3 with no underwear, and this had been an going concern when R2 moved from the transitional care unit (TCU) to the long term care (LTC) on 4/26/21. A care conference was held 5/17/21, at 8:00 a.m. to address the dressing concern along with other concerns. F-A reported said after the first time F-A complained to the facility, the information for dressing was added to care plan and any disposable briefs were removed from R2's room. At 12:22 p.m. F-A requested to take R2 out to lunch. R2 remained without underwear and F-A assisted R2 and put on underwear. During interview on 5/27/21 at 1:48 p.m. assistant director or nursing (ADON) stated the expectation was staff would ensure all residents have the appropriate attire and that would include undergarments, pants, shirts, shoes and socks.	F 561		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		6/3/21

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F 656	Continued From page 4 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with catheter cares for 1 of 3 resident (R2) reviewed for indwelling catheter. Findings include: R2's admission Minimum Data Set (MDS) dated 4/26/21, indicated R2 had a brief inventory of mental status (BIMS) score of 5, that indicated severe cognitive impairment and received total assistance to complete dressing and grooming.	F 656	R1 was assisted with catheter care at the time of survey. R1□s care plan was reviewed and revised as needed. All residents with an indwelling catheter have the potential to be affected. Care Plans for resident□s potentially affected have been reviewed Facility policy for Care Plans was reviewed. Licensed Nurses and Nursing Assistants received education on	

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F 656	Continued From page 5 R2 had not rejected cares. The MDS identified medical diagnoses that included Alzheimer's disease and dementia in other diseases with behavior disturbance, neurogenic bladder (nervous system condition causing loss of bladder control) and obstructive uropathy (a condition where urine backs up into the kidneys). R2 had a suprapubic catheter (a permanent catheter placed into the abdomen for urinary elimination). R2's care plan dated 4/26/21, directed staff to empty catheter bag every 1-2 hours. During an observation on 5/17/21, at 9:56 a.m. R2 sat in commons area and visited with other residents. R2 was dressed and wore a leg catheter bag (a bag worn around the leg under clothing for dignity purposes). R2's catheter bag was visibility inflated through his pants, an indication there was urine in the bag. Family (F)-A noted there was was approximately 200 cubic centimeters (cc) in R2's leg bag. During an interview at 12:22 p.m. F-A stated at 10:50 a.m. nursing assistant (NA)-A came to R2's room and stated, "time for lunch soon," no cares were provided. F-A checked R2's catheter bag again and said there was approximately 400 cc. in the leg bag. F-A stated, at the time of the interview, that she wanted to take R2 out facility for lunch and asked NA-A to empty the bag so R2 could leave the facility. NA-A emptied the bag, and the measured amount of urine was 450 cc. During an interview on 5/17/21, at 12:35 p.m. NA-A stated she emptied the bag when she got R2 up and dressed around 9:15 a.m. NA-A	F 656	implementing interventions as they are listed on the care plan/Kardex Monitoring to ensure compliance will be done through weekly facility audits on Implementation of Care Planned Interventions Interim DON or designee will be responsible. The facility will review audit results at monthly QA/QAPI meetings and make recommendations as indicated. This deficiency will be corrected by 6/3/21.	

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F 656	Continued From page 6 confirmed R2's bag had not been emptied since that time and NA-A was aware R2's leg bag needed to be emptied every 1-2 hours. During an interview on 5/17/21, at 1:48 p.m. The assistant director of nursing (ADON) stated that staff were to follow what is written on the plan of care.	F 656		

Electronically delivered
May 21, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: U9Z611

Dear Administrator:

The above facility was surveyed on May 17, 2021 through May 17, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Sarah Grebenc, Unit Supervisor
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
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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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 05/17/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000	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.	

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5055282C (MN72415) with a licensing order issued at 0565 and 1830. The following complaint was found to be UNSUBSTANTIATED: H5055280C (MN72615/MN72763). No deficiency.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		6/3/21

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	00276	A. BUILDING: _____ B. WING _____	C 05/17/2021

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2 565	Continued From page 2 by: Based on observation, interview and document review, the facility failed to provide timely assistance with catheter cares for 1 of 3 resident (R2) reviewed for indwelling catheter. Findings include: R2's admission Minimum Data Set (MDS) dated 4/26/21, indicated R2 had a brief inventory of mental status (BIMS) score of 5, that indicated severe cognitive impairment and received total assistance to complete dressing and grooming. R2 had not rejected cares. The MDS identified medical diagnoses that included Alzheimer's disease and dementia in other diseases with behavior disturbance, neurogenic bladder (nervous system condition causing loss of bladder control) and obstructive uropathy (a condition where urine backs up into the kidneys). R2 had a suprapubic catheter (a permanent catheter placed into the abdomen for urinary elimination). R2's care plan dated 4/26/21, directed staff to empty catheter bag every 1-2 hours. During an observation on 5/17/21, at 9:56 a.m. R2 sat in commons area and visited with other residents. R2 was dressed and wore a leg catheter bag (a bag worn around the leg under clothing for dignity purposes). R2's catheter bag was visibility inflated through his pants, an indication there was urine in the bag. Family (F)-A noted there was was approximately 200 cubic centimeters (cc) in R2's leg bag. During an interview at 12:22 p.m. F-A stated at 10:50 a.m. nursing assistant (NA)-A came to R2's	2 565	Correction Date of 6/3/21.	

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2 565	Continued From page 3 room and stated, "time for lunch soon," no cares were provided. F-A checked R2's catheter bag again and said there was approximately 400 cc. in the leg bag. F-A stated, at the time of the interview, that she wanted to take R2 out facility for lunch and asked NA-A to empty the bag so R2 could leave the facility. NA-A emptied the bag, and the measured amount of urine was 450 cc. During an interview on 5/17/21, at 12:35 p.m. NA-A stated she emptied the bag when she got R2 up and dressed around 9:15 a.m. NA-A confirmed R2's bag had not been emptied since that time and NA-A was aware R2's leg bag needed to be emptied every 1-2 hours. During an interview on 5/17/21, at 1:48 p.m. The assistant director of nursing (ADON) stated that staff were to follow what is written on the plan of care. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure care plans were followed. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment;	21830		6/3/21

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21830	Continued From page 4 notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility;	21830		

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21830	Continued From page 5	21830		

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for

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21830	Continued From page 6 damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in a manner that promoted self determination for 1 of 3 (R2) reviewed for choices regarding undergarment attire. Findings include: R2's admission Minimum Data Set (MDS) dated 4/26/21, indicated R2 had a brief inventory of mental status (BIMS) score of 5, that indicated severe cognitive impairment and received total assistance from staff to dress and groom. R2 had not rejected cares. The MDS identified medical diagnoses that included Alzheimer's disease and dementia in other diseases with behavior disturbance. MDS indicated R2 was continent of bowel and occasionally incontinent of bladder. R2 has a suprapubic catheter (a catheter inserted into the stomach for elimination of urine). R2's care plan dated 4/26/21, identified R2 needed total assistance of staff to dress and directed staff to assist with all grooming. Also noted on the care plan, family (F)-A, preferred R2 to wear underwear, not a disposable brief. During an interview on 5/17/21, at 10:39 a.m. nursing assistant (NA)-A reported she had dressed R2 that morning. NA-A reported she looked for a brief in the room and the licensed	21830	Correction date of 6/3/21.	

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21830	Continued From page 7	21830		

practical nurse (LPN)-A told NA-A to not put a brief on R2 per family. NA-A reported there was no underwear in the room for R2 and all clothes were in the laundry.

During an interview on 5/17/21, at 11:04 a.m. F-A said they arrived to facility on 5/17/21, at 10:11 am. R2 was done with breakfast and was in the community area with other residents. F-A indicated they checked R2 and found he only wore pants and did not have any underwear on. F-A reported that at least 15 pair of underwear were brought to facility upon admission of 4/26/21, and have always been in R2's drawer in the room. F-A proceeded to show the top dresser drawer full of underwear clean and folded. F-A reported R2 was either put in a disposable brief or pants with no underwear, and this had been an going concern when R2 moved from the transitional care unit (TCU) to the long term care (LTC) on 4/26/21. A care conference was held 5/17/21, at 8:00 a.m. to address the dressing concern along with other concerns. F-A reported said after the first time F-A complained to the facility, the information for dressing was added to care plan and any disposable briefs were removed from R2's room.

At 12:22 p.m. F-A requested to take R2 out to lunch. R2 remained without underwear and F-A assisted R2 and put on underwear.

During interview on 5/27/21 at 1:48 p.m. assistant director or nursing (ADON) stated the expectation was staff would ensure all residents have the appropriate attire and that would include undergarments, pants, shirts, shoes and socks.

SUGGESTED METHOD OF CORRECTION: The director of nursing or social services could

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21830	Continued From page 8 in-service staff on the need to honor resident requests especially for choice in clothing. Also monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		