MDH Minnesota Department of Health

## Office of Health Facility Complaints Investigative Report
**PUBLIC**

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| **Facility Name:** Walker Methodist Westwood Ridge | | **Report Number:** H5618003 | **Date of Visit:** April 18, 2017 |
| **Facility Address:** 190 West Chester Drive | | **Time of Visit:** 9:30 a.m. to 4:30 p.m. | **Date Concluded:** January 3, 2018 |
| **Facility City:** West St. Paul | | **Investigator's Name and Title:** Arthur Biah, RN, Special Investigator | |
| **State:** Minnesota | **ZIP:** 55118 | **County:** Ramsey | |

☒ **Nursing Home**

### Allegation(s):
It is alleged that a resident was neglected when the alleged perpetrator (AP) failed to transcribe hospital-discharge orders resulting in the resident not receiving proper required medications and resident's condition declined quickly. The resident was sent to the ER.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

### Conclusion:
Based on preponderance of evidence, neglect is substantiated. The alleged perpetrator (AP) failed to obtain accurate discharge orders when the resident was discharged from the hospital to the facility. The AP processed the resident's prior hospital discharge summary instead of the current hospital discharge orders. The facility did not administer the resident's heart medications ordered by the physician when s/he was admitted to the facility. As a result, the resident's heart stent clotted, the resident was readmitted to the hospital, and had another stent placed.

The resident was admitted to the facility for short-term rehabilitation with diagnoses of myocardial infarction, diabetes mellitus type 2, and respiratory failure. The resident was alert, oriented, and able to make needs known to staff. S/he needed one-person assistance with transfers and ambulation.

The resident was admitted to the facility with discharge orders to discontinue Plavix (a medication used to prevent blood cells from sticking together and forming blood clots). The resident's discharge order required the facility to administer Brilinta (a medication used to prevent blood cells from sticking together and forming blood clots) and Imdur (a medication used to prevent chest pain). The hospital record indicated the

resident was discharged to the facility to continue rehabilitation for strengthening.

Two days after the discharge, the resident complained of chest pain and was sent the hospital's emergency department via ambulance. The hospital record indicated the resident had the previous stent clotted with another heart attack. The hospital record indicated the clotted stent and heart attack was due to the facility not administering the new therapy of Brilinta and Imdur as ordered, and continuing to administer the discontinued Plavix. The resident had another stent placed and the facility was instructed to maintain the physician's orders of Brilinta and Imdur, not the Plavix medication.

The facility admission record indicated the AP entered the wrong admission order, including all medications from the previous hospital admission. The record indicated the AP verified and co-signed the inaccurate admission order. Two days after the resident's admission, the resident complained of chest pain and was readmitted to the hospital. The AP stated s/he did not remember reviewing the inaccurate admission order, could not remember s/he signed the resident's admission progress note, or worked on the day of the incident. The staff schedule on the day of the incident indicated the AP reviewed and signed the admission orders on the day of the incident.

During an interview, the director of nursing stated when the resident was admitted to the facility. A staff and AP used an unsigned discharge summary from previous hospital discharge to transcribe the resident's medications for the second admission to the facility. Staff administered Plavix based on the inaccurate medication list and did not administer the resident's new medications, which was to prevent blood clot after stenting and/or chest pain.

During an interview, the resident's heart physician stated the resident was previously admitted to the hospital with clotted blood vessels. The physician stated s/he performed a procedure to place heart stent within the blood vessels. The physician stated, in order to prevent future clot, s/he ordered the resident receive Brilinta and Imdur to protect the new stent and prevent further chest pain. The physician stated when the resident readmitted to the hospital, there was a report that the facility had continued to administer the previously, discontinued Plavix, instead of the administering the Brilinta and Imdur which had been prescribed. The physician stated resident's stent re-clotted because facility failed to continue the Brilinta therapy. The physician stated the resident had not been readmitted to the hospital since s/he had been taking the Brilinta as prescribed.

During an interview, the resident stated s/he had not been hospitalized since he was last discharged on Brilinta and had taken the them as prescribed by the physician.

The AP was terminated from the facility.

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Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

Facility Name: Walker Methodist Westwood Ridge

Report Number: H5618003

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

**Mitigating Factors:**

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the ☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

Multiple staff failed to follow the facilities policy and procedure to ensure a resident was administered the correct medication as prescribed upon admission to the facility.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

**Compliance:**

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

**Compliance Notes:**

## Definitions:

**Minnesota Statutes, section 626.5572, subdivision 17 - Neglect**

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

**Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated**

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

## The Investigation included the following:

**Document Review: The following records were reviewed during the investigation:**

- [X] Medical Records
- [X] Medication Administration Records
- [X] Nurses Notes
- [X] Physician Orders
- [X] Physician Progress Notes
- [X] Facility Incident Reports

## Other pertinent medical records:

- [X] Hospital Records

**Additional facility records:**

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Five

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: _____

**Interviews: The following interviews were conducted during the investigation:**

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

| Date: | Time: | Date: | Time: | Date: | Time: |
|---|---|---|---|---|---|
| | | | | | |

Interview with family: ○ Yes ○ No ◉ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Six

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

**Tennessen Warnings**

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Six

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

**Observations were conducted related to:**

☒ Nursing Services

☒ Medication Pass

☒ Cleanliness

☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

**Health Regulation Division - Licensing & Certification**

**Minnesota Board of Nursing**

**The Office of Ombudsman for Long-Term Care**

**West St. Paul Police Department**

**Ramsey County Attorney**

**Saint Paul City Attorney**

DEPARTMENT OF HEALTH

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

Electronically delivered
November 29, 2017

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: Project Number H5618003

Dear Ms. Schrupp:

On September 18, 2017, an abbreviated standard survey related to a complaint investigation was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiency in your facility to be an isolated deficiency that constituted actual harm that was not immediate jeopardy (Level G). A copy of the Statement of Deficiencies (CMS-2567) is being delivered electronically.

This letter provides important information regarding your response to the deficiencies and addresses the following issues:

> Remedies - the type of remedies that may be imposed by the Centers for Medicare and Medicaid Services (CMS);
>
> Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

DEPARTMENT CONTACT

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

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204 Fax: (651) 281-9796

The current survey found the most serious deficiency in your facility to be an isolated deficiency that constituted actual harm that was not immediate jeopardy (Level G). Therefore this department will recommend to the CMS Regional V Office, the following enforcement remedy:

- Civil money penalty for deficiency cited at F333. (42 CFR 488.430 through 488.444).

If the Centers for Medicare and Medicaid Services (CMS) decides to impose this recommended remedy they will send you a notice of imposition of the remedy and appeal rights.

INFORMAL DISPUTE RESOLUTION

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 Policy, Information and Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within ten days. 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
A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin web site 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 the imposition of remedies.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

| 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 _____ | C 09/18/2017 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>****AMENDED****<br><br>This 2567 will replace the 2567 sent on October 17, 2017.<br><br>An abbreviated standard survey was conducted to investigate case #H5618003. As a result, the following deficiency is issued at past noncompliance for F333 related to the facilities failure to ensure the correct medication was administered as prescribed. A plan of correction is not required for past noncompliance, since the deficiency is already corrected; however the facilities past noncompliance and the corrective actions are documented on the CMS-2567 form.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission acknowledging the CMS-2567 form is required. | F 000 | | |
| F 333 SS=G | RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br>CFR(s): 483.45(f)(2)<br><br>483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and interviews, the facility failed to ensure a resident was administered the correct medication upon | F 333 | Past noncompliance: no plan of correction required. | 11/29/17 |

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

Electronically Signed | 10/27/2017

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| F 333 | Continued From page 1<br>admission for one of six residents, (R1), reviewed when R1 was admitted from the hospital February 7, 2017 with previous discharge orders dated February 1, 2017. R1 did not receive his prescribed Brilinta 90 milligrams (mg), a medication used to prevent heart attack after stent placement, and Imdur 30 mg, a medication used to prevent chest pain medications for two days. R1 was harmed when R1 was re-hospitalized for two days with a clotted stent, and required another stent placement.<br><br>The facility was not in compliance on February 7, 2017 when R1 did not receive his prescribed Brilinta 90 milligrams (mg), a medication used to prevent heart attack after stent placement, and Imdur 30 mg, a medication used to prevent chest pain medications for two days. R1 was harmed when R1 was re-hospitalized for two days with a clotted stent, and required another stent placement. However, the facility corrected the noncompliance and was in compliance at the time of the onsite visit April 18, 2017 when it was verified corrective action was taken.<br><br>Findings include:<br><br>R1's medical record was reviewed. R1 was admitted to the facility for short-term rehabilitation with diagnoses of myocardial infarction, diabetes mellitus type 2, and respiratory failure. R1 was alert, oriented, and able to make needs known to staff. R1 needed one staff assistance with transfers, ambulation, and needed staff assistance for medication administration. R1 was administered wrong medications based on inaccurate medication list from previous discharge that was used by facility admission staff. | F 333 | | |

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| F 333 | Continued From page 2<br><br>The hospital discharge record dated February 7, 2017 indicated R1 was discharged from the hospital to the facility after admission with heart attack. The discharge order indicated R1 had a drug-eluting stent placed and started on new therapy of twice-daily Brilinta 90 milligrams (mg), a medication used to prevent heart attack after stent placement, and Imdur 30 mg, a medication used to prevent chest pain, daily. The resident's previous order of Plavix 75 mg was discontinued. R1 was discharged to the facility on February 7, 2017 to continue rehabilitation for strengthening.<br><br>The hospital discharge record received for R1's February 7, 2017 admission to the facility was titled Discharge Summary dated for R1's hospital admission on January 24, 2017 and discharge on February 1, 2017. The hospital record indicated the date of service as February 1, 2017, not the actual day of admission to the facility, which was February 7, 2017.<br><br>The facility's admission order report for R1 dated February 7, 2017 indicated a Plavix order (a medication to prevent blood clot from forming) with instruction to take 75 milligrams (mg) by mouth daily for coronary artery disease. The order report did not contain an order to discontinue Plavix, nor orders for a new therapy of Brilinta and Imdur to prevent blood clot and chest pain.<br><br>The facility's medication administration record (MAR) dated February 1 to 28, 2017 indicated R1 was administered Plavix 75 mg daily on February 8 and 9, 2017. The MAR was based on the wrong discharge information and had no record of Brilinta and Imdur administration. | F 333 | | |

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| F 333 | Continued From page 3<br><br>The facility's investigative report dated February 9, 2017 indicated R1 reported chest pain, rated at eight on a zero to ten scale, and was sent to the emergency room at the hospital.<br><br>R1's hospital record dated February 11, 2017 indicated R1 was readmitted to the hospital's emergency department via ambulance on February 9, 2017 for chest pain. The hospital record indicated R1 had a clotted stent and another heart attack due to Plavix resistance or failure. R1 had a new stent placed. During this hospital stay, the hospital record indicated the facility had continued to administer R1 the Plavix discontinued during the February 7 to 9, 2017 admission.<br><br>The director of nursing (DON) was interviewed on April 18, 2017 at 10:58 a.m. and stated when the resident was admitted to the facility on February 7, 2017, the staff used an unsigned discharge instruction from previous discharge to transcribe R1's medications. The DON stated the facility's staff administered R1's medications based on the inaccurate medication list including a discontinued medication, Plavix. The DON stated the facility staff did not administer the resident's new medications started to prevent blood clot after stenting and/or chest pain because they (staff) did not ensure the admission order was accurate and signed by a physician. The DON<br><br>The admission registered nurse (RN)-D was interviewed on April 18, 2017 at 3:13 p.m. and stated he did not remember reviewing R1's admission order. Even though RN-D electronically signed R1's admission order report and nursing progress note dated February 7, | F 333 | | |

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| F 333 | Continued From page 4<br>2017, RN-D stated s/he did not remember working on the day of incident.<br><br>R1's cardiologist was interviewed on August 3, 2017 at 3:55 p.m. and stated the resident was previously admitted to the hospital with clotted blood vessels, and s/he performed stenting of the blood vessels. The cardiologist stated, in order to prevent future clot, s/he discharged the resident with instruction to take Brilinta and Imdur in order to protect the new stent and prevent chest pain. The cardiologist stated when the resident readmitted to the hospital, there was a report that the facility had continued to administer the previously discontinued Plavix, instead of the prescribed Brilinta and Imdur. The cardiologist stated not continuing the Brilinta as prescribed could have caused the resident's stent to be clotted in two to three days. The cardiologist stated the resident had not been readmitted to the hospital since s/he had been taking the Brilinta as prescribed.<br><br>R1 was interviewed on August 7, 2017 at 9:43 a.m. and stated the hospital told him he was given Plavix at the facility when he should have been taking Brilinta. R1 stated he was hospitalized for not getting the accurate medication ordered.<br><br>Registered nurse (RN)-G was interviewed on August 7, 2017 at 10:35 a.m. and stated the facility did not have a procedure to verify if the date on the discharge order is accurate to match residents' hospital stay, including discharge date.<br><br>The facility's policy and procedure titled "Physician Orders-Patient Care Services", dated January 3, 2014, indicated admission orders from | F 333 | | |

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| F 333 | Continued From page 5<br>a discharging facility must be signed by a physician. The policy indicated all orders are to be second checked by a licensed nurse and the second nurse is to verify that the transcription is accurate. The policy indicated the night shift licensed nurse would conduct the 24-hour check process to ensure each order was correct on electronic MAR or electronic treatment administration record per the physician's order.<br><br>The past noncompliance that began on February 7, 2017 was found corrected on April 18, 2017 during an onsite visit. Verification of corrective action was confirmed by review of documentation and interviews. Five resident records, who were admitted after the incident of R1, were reviewed for verification of current admission orders with a physician signature and compared the resident medication admission records. A physician signed all five resident records reviewed and the medication orders correctly corresponded to the resident admission medication record. Five residents were interviewed for concerns of medication administration after admission and all residents stated they received the correct medications. Two licensed practical nurses, three registered nurses, and one health unit coordinator were interviewed regarding staff education for dated admission orders with a physician signature and all staff indicated the facility conducted reeducation following the incident. The facility's audit of all new admissions after the incident was completed to ensure the accuracy of physician orders and the audit findings were brought to the facility's quality assurance committee to determine the need for additional training. | F 333 | | |

DEPARTMENT OF HEALTH

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

Electronically delivered

February 1, 2018

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: Enclosed Reinspection Results - Complaint Number H5618003

Dear Ms. Schrupp:

On January 9, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on September 18, 2017. At this time these correction orders were found corrected.

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,

Annette Winters, Supervisor
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4204 Fax: (651) 281-9796

Enclosure(s)

cc: Licensing and Certification File

Minnesota Department of Health

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| | 27996 | A. BUILDING: _____ B. WING _____ | R-C 01/09/2018 |

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| {2 000} | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5618003. Walker Methodist Westwood Ridge II was found in compliance with state regulations.<br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first | {2 000} | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 27996 | A. BUILDING: _____ B. WING _____ | R-C 01/09/2018 |

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

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| {2 000} | Continued From page 1<br>page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | {2 000} | | |

DEPARTMENT OF HEALTH

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

Electronically delivered
October 17, 2017

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

Re: Enclosed State Nursing Home Licensing Orders - Complaint Number H5618003

Dear Ms. Schrupp:

A complaint investigation was completed on September 18, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

If you have questions or concerns you may call me at the number below.

Sincerely,

Kate Johnston

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>A complaint investigation was conducted to investigate complaint #H5618003. As a result, the following correction order is issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at | 2 000 | | |

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| 2 000 | Continued From page 1<br>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. | 2 000 | | |
| 21850 | MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.<br><br>This MN Requirement is not met as evidenced by:<br>Based on document review and interviews, the facility failed to ensure a resident was free from maltreatment for one of six residents, (R1), reviewed when R1 was admitted from the hospital | 21850 | THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 11/2/17 |

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| 21850 | Continued From page 2<br><br>February 7, 2017 with previous discharge orders dated February 1, 2017. R1 did not receive his prescribed Brilinta 90 milligrams (mg), a medication used to prevent heart attack after stent placement, and Imdur 30 mg, a medication used to prevent chest pain medications for two days. R1 was harmed when R1 was re-hospitalized for two days for a clotted stent, and required another stent placed.<br><br>Findings include:<br><br>The facility's policy and procedure titled "Vulnerable Adult Reporting and Abuse Prevention" and dated November 28, 2016 indicated each resident will be free from neglect.<br><br>The facility's policy and procedure titled "Physician Orders-Patient Care Services", dated January 3, 2014, indicated admission orders from a discharging facility must be signed by a physician. The policy indicated all orders are to be second checked by a licensed nurse and the second nurse is to verify that the transcription is accurate. The policy indicated the night shift licensed nurse would conduct the 24-hour check process to ensure each order was correct on electronic MAR or electronic treatment administration record per the physician's order.<br><br>R1's medical record was reviewed. R1 was admitted to the facility for short-term rehabilitation with diagnoses of myocardial infarction, diabetes mellitus type 2, and respiratory failure. R1 was alert, oriented, and able to make needs known to staff. R1 needed one staff assistance with transfers, ambulation, and needed staff assistance for medication administration. R1 was administered wrong medications based on inaccurate medication list from previous | 21850 | | |

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| 21850 | Continued From page 3<br>discharge that was used by facility admission staff.<br><br>The hospital discharge record dated February 7, 2017 indicated R1 was discharged from the hospital to the facility after admission with heart attack. The discharge order indicated R1 had a drug-eluting stent placed and started on new therapy of twice-daily Brilinta 90 milligrams (mg), a medication used to prevent heart attack after stent placement, and Imdur 30 mg, a medication used to prevent chest pain, daily. The resident's previous order of Plavix 75 mg was discontinued. R1 was discharged to the facility on February 7, 2017 to continue rehabilitation for strengthening.<br><br>The hospital discharge record received for R1's February 7, 2017 admission to the facility was titled Discharge Summary dated for R1's hospital admission on January 24, 2017 and discharge on February 1, 2017. The hospital record indicated the date of service as February 1, 2017, not the actual day of admission to the facility, which was February 7, 2017.<br><br>The facility's admission order report for R1 dated February 7, 2017 indicated a Plavix order (a medication to prevent blood clot from forming) with instruction to take 75 milligrams (mg) by mouth daily for coronary artery disease. The order report did not contain an order to discontinue Plavix, nor orders for a new therapy of Brilinta and Imdur to prevent blood clot and chest pain.<br><br>The facility's medication administration record (MAR) dated February 1 to 28, 2017 indicated R1 was administered Plavix 75 mg daily on February 8 and 9, 2017. The MAR was based on the wrong discharge information and had no record of | 21850 | | |

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| 21850 | Continued From page 4<br>Brilinta and Imdur administration.<br><br>The facility's investigative report dated February 9, 2017 indicated R1 reported chest pain, rated at eight on a zero to ten scale, and was sent to the emergency room at the hospital.<br><br>R1's hospital record dated February 11, 2017 indicated R1 was readmitted to the hospital's emergency department via ambulance on February 9, 2017 for chest pain. The hospital record indicated R1 had a clotted stent and another heart attack due to Plavix resistance or failure. R1 had a new stent placed. During this hospital stay, the hospital record indicated the facility had continued to administer R1 the Plavix discontinued during the February 7 to 9, 2017 admission.<br><br>The director of nursing (DON) was interviewed on April 18, 2017 at 10:58 a.m. and stated when the resident was admitted to the facility on February 7, 2017, the staff used an unsigned discharge instruction from previous discharge to transcribe R1's medications. The DON stated the facility's staff administered R1's medications based on the inaccurate medication list including a discontinued medication, Plavix. The DON stated the facility staff did not administer the resident's new medications started to prevent blood clot after stenting and/or chest pain because they (staff) did not ensure the admission order was accurate and signed by a physician. The DON<br><br>The admission registered nurse (RN)-D was interviewed on April 18, 2017 at 3:13 p.m. and stated he did not remember reviewing R1's admission order. Even though RN-D electronically signed R1's admission order report and nursing progress note dated February 7, | 21850 | | |

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| 21850 | Continued From page 5<br>2017, RN-D stated s/he did not remember working on the day of incident.<br><br>R1's cardiologist was interviewed on August 3, 2017 at 3:55 p.m. and stated the resident was previously admitted to the hospital with clotted blood vessels, and s/he performed stenting of the blood vessels. The cardiologist stated, in order to prevent future clot, s/he discharged the resident with instruction to take Brilinta and Imdur in order to protect the new stent and prevent chest pain. The cardiologist stated when the resident readmitted to the hospital, there was a report that the facility had continued to administer the previously discontinued Plavix, instead of the prescribed Brilinta and Imdur. The cardiologist stated not continuing the Brilinta as prescribed could have caused the resident's stent to be clotted in two to three days. The cardiologist stated the resident had not been readmitted to the hospital since s/he had been taking the Brilinta as prescribed.<br><br>R1 was interviewed on August 7, 2017 at 9:43 a.m. and stated the hospital told him he was given Plavix at the facility when he should have been taking Brilinta. R1 stated he was hospitalized for not getting the accurate medication ordered.<br><br>Registered nurse (RN)-G was interviewed on August 7, 2017 at 10:35 a.m. and stated the facility did not have a procedure to verify if the date on the discharge order is accurate to match residents' hospital stay, including discharge date.<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, | 21850 | | |

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| 21850 | Continued From page 6<br>educated staff on revisions, and monitor to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days. | 21850 | | |

DEPARTMENT OF HEALTH

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

Electronically delivered
November 29, 2017

Ms. Brenda Schrupp, Administrator
Walker Methodist Westwood Ridge II
61 Thompson Avenue West
West Saint Paul, MN 55118

RE: Project Number H5618003

Dear Ms. Schrupp:

On September 18, 2017, an abbreviated standard survey related to a complaint investigation was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiency in your facility to be an isolated deficiency that constituted actual harm that was not immediate jeopardy (Level G). A copy of the Statement of Deficiencies (CMS-2567) is being delivered electronically.

This letter provides important information regarding your response to the deficiencies and addresses the following issues:

> Remedies - the type of remedies that may be imposed by the Centers for Medicare and Medicaid Services (CMS);
>
> Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

DEPARTMENT CONTACT

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

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204 Fax: (651) 281-9796

The current survey found the most serious deficiency in your facility to be an isolated deficiency that constituted actual harm that was not immediate jeopardy (Level G). Therefore this department will recommend to the CMS Regional V Office, the following enforcement remedy:

- Civil money penalty for deficiency cited at F333. (42 CFR 488.430 through 488.444).

If the Centers for Medicare and Medicaid Services (CMS) decides to impose this recommended remedy they will send you a notice of imposition of the remedy and appeal rights.

INFORMAL DISPUTE RESOLUTION

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 Policy, Information and Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within ten days. 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
A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin web site 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 the imposition of remedies.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697