STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	04/10/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to thoroughly investigate allegations of abuse and protect residents for 2 of 3 residents (R1 and R2) reviewed for staff to resident abuse allegations. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], identified R1 was cognitively intact and independent with all activities of daily living (ADLs). The MDS further identified R1's [DIAGNOSES REDACTED]. A facility report dated [DATE], indicated on 4/5/20 R1 reported an altercation involving R1 and license practical nurse (LPN)-A. R1 reported that LPN-A backed R1 into a corner and yelled at R1. R1's care plan last revised 4/8/20, indicated R1 had a potential risk of abuse from others related to admission. The care plan further indicated R1 had a history of [REDACTED]. When interviewed on 4/8/20, at 9:42 a.m. R1 stated there have been several interactions between self and LPN-A and they have, locked horns, several times. R1 reported that LPN-A has threatened R1 with words like, I can do anything I want to you and there is nothing you can do about it. R1 stated, (LPN-A) scares me .(LPN-A) is working here on the floor today. When interviewed on 4/8/20, at 10:28 a.m. registered nurse (RN)-A confirmed an interview with R1 in which R1 reported being cornered by LPN-A over the weekend. RN-A stated, I started the investigation but have not completed the investigation. I have interviewed some others and have a few more to speak with. RN-A further stated, I pulled (LPN-A) off the case (cannot work with R1), RN-A further stated, (LPN-A) is not here now, (LPN-A) may have been here earlier, but I did not see (LPN-A) this morning, but I did not get here until 9 am. But (LPN-A) is off the case (R1's care). When interviewed on 4/8/20, at 10:57 a.m. LPN-B stated there are typically three nurses scheduled on this floor. LPN-B verified and stated, The third nurse (LPN-A) was here this morning and for some reason (LPN-A) left. When interviewed on 4/8/20, at 11:06 a.m. RN-B stated, Not sure why (LPN-A) left. (LPN-A) was here this morning but not any longer. When interviewed on 4/8/20, at 12:13 p.m. family member (FM)-A stated, (LPN-A) has threatened him. I have never heard it personally. But (R1) does try to be protective of the situation. In (LPN-A's) tone and demeanor. I have never met (LPN-A). I have not visited in about a year. I was living out of state. All the incidences were described to me over the phone. It sounds dysfunctional from what I can understand .It was yesterday or the day before, this nurse was using very threatening tone with (R1). When interviewed on 4/8/20, at 2:42 p.m. LPN-A stated, From the second I clocked in that morning, (R1) would reposition self and (R1) would, stalk me. I was incredibly uncomfortable and called my nurse manager and (my nurse manager) said to be very careful. LPN-A denied yelling at R1 and denied previous accusations of putting R1 in a headlock and making rude gestures to R1. LPN-A further stated, Today (4/8/20) I was shocked when I walked on the floor and saw (R1) glaring at me. The last two days were my days off. This morning, I went right to (RN-C) and said I can't deal with this today. So I went home and I don't unnerve very easily but (R1) gets to me and scares me. LPN-A confirmed RN-A interviewed LPN-A on [DATE]. LPN-A stated, (RN-A) said I would not be working with (R1). I would not be working on the odd side so I would not be coming in contact with (R1). When interviewed on 4/9/20, at 2:30 p.m. director of nursing (DON) stated, During the investigation, if it was an abuse (allegation) we would totally remove (the alleged perpetrator) either totally from the schedule or send to another unit. I would not allow that staff to work if abuse was the allegation and the interviews and investigation was not complete. The investigation has to be done. I would say unless the investigation was done or the threat was done they would be off the schedule. When reviewed on 4/8/20, at 10:18 a.m. the daily schedule list at the fifth floor nurse's station indicated LPN-A was assigned to the unit 7:00 a.m. to 3:15 pm on Wednesday, April 8, 2020. When reviewed on 4/8/20, 2:30 p.m. the investigation file provided by the facility indicated the same information as the complaint report which indicated completed interviews of R1 and LPN-A. No further interviews were documented. The action taken indicated, Safety ensured, nurse off of the schedule, internal investigation initiated. However, LPN-A had remained on the schedule with the plan for her only not to work with R1. The facility had not protected residents while the investigation was ongoing. R3 voiced concern on 12/2/19, that over the prior weekend LPN-A was, a bully and yells at (R3). This was reported to the State Agency on 12/2/19, through the Nursing Home Incident Reporting Website. Per the submitted incident report, the facility started an investigation, and LPN-A was not scheduled to work again until 12/[DATE]9, and would be changed to a different unit upon return to not work with R3. The facility's internal investigation file included evidence of additional interviews with involved staff and R3. Staff documented on an Issue and Concern form dated 12/2/19, R3 initially expressed wanting to transfer to another care unit, because R3 felt one of the nurses was a bully, and scared R3. R3 stated LPN-A yelled at R3, and used an intimidating tone when arguing with R3 about not wanting to take [MED]. Per the file, another staff person was interviewed on 12/3/19, and stated LPN-A could be, a bit loud, and with an, abrupt, approach, but had no other concerns and described LPN-A as helpful. LPN-A was interviewed on 12/3/19, and stated R3 wanted to refuse [MED] over the weekend, so LPN-A explained R3's right to refuse medication, but also gave the pros and cons of taking the medication. R3 decided to take the medication, and LPN-A was never told at the time about being too loud, nor did R3 inform LPN-A about any concerns at the time of the incident. When R3 was interviewed again on 12/3/19, staff documented R3 denied that anyone was rough or aggressive with her, but stated LPN-A was, verbally abusive - like (R3's) ex-husband used to be - (LPN-A) yells, not listens. The facility Investigation Report was submitted to the State on 12/6/19, and noted that R3 reported, The nurse's voice and demeanor reminded (R3) of (R3's) ex-husband and triggered memories of past abuse. The resident denied being mistreated by the employee and stated (R3) felt safe in the facility. LPN-A returned to work on 12/[DATE]9, per the Employee Shift Finder schedule, and worked on a different floor than R3. The facility investigation file did not include evidence that other residents were interviewed about whether they felt safe, or had ever felt yelled at, intimidated, or abused by staff. On 4/8/20, at 2:42 p.m. LPN-A described getting along well with R3, and being surprised by the allegation. When asked if LPN-A was suspended from working after the allegation was made, LPN-A stated was not ever suspended, but was moved to work on a different unit. During a phone interview on 4/9/20, at 12:19 p.m. the assistant director of nursing (ADON) explained staff with allegations of abuse are always initially suspended at the time of the allegation, and are off for at least the next day, so staff can interview other residents to make sure they feel safe before staff return to work. During a follow-up phone interview at 3:34 p.m., the ADON confirmed that LPN-A was not working at the time the allegation was reported on 12/2/19, and happened to have the day off 12/3/19. ADON confirmed LPN-A returned to work as scheduled 12/[DATE]9, because after talking to R3 a second time, R3 seemed to recant abuse, stating that LPN-A reminded R3 of someone from the past who caused R3 trauma. ADON confirmed that no other residents were interviewed after that, because staff determined it was an isolated incident having to do more with the resident's history of abuse. Vulnerable Adult Abuse Prevention Plan and Suspicion of a Crime Reporting policy, last revised 11/1/19, required the resident to be protected from further abuse by removing the alleged perpetrator from the resident's care area and/or place the alleged perpetrator under supervision until directed otherwise.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Based on interview and document review, the facility failed to implement and follow appropriate measures to assess residents for symptoms of COVID-19. The facility failed to check and document resident temperatures daily for 31 of 50 residents (R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31 and R32) who were randomly reviewed for COVID-19 infection monitoring. Findings include: When interviewed on 4/8/20, at 4:58 p.m. license practical nurse (LPN)-B stated, The nurses are responsible for checking temps not sure how often, I check them in the morning. LPN-B further stated the resident's temperature was documented under vital signs in Point Click Care (PCC). SpO2 (a measure of the amount of [MED]gen in the blood) was also check and documented under vital signs, and all other vital signs are taken and documented weekly with the body audit. We ask them how they feel and do they have a cough. We ask this with temp. If someone has a temp, we tell the manager and nurse practitioner (NP) and will put the resident in isolation until we get the swab results. LPN further stated that the nurse would document in progress notes if the resident displayed respiratory symptoms. If the resident did not have any symptoms, the nurse was not expected to write a note because they chart by exception. Not with temps though, we are supposed to record all temps in PCC. When interviewed on 4/9/20, at 11:15 a.m. infection control preventionist (ICP) stated, We are checking temps twice a day morning and evening and we screen for cough, shortness of breath and fever. We just added diarrhea yesterday. If anyone is showing signs they are then placed on conditional q4 hour (every 4 hour) checks. ICP confirmed vital signs were always documented under the vital signs in PCC. ICP further confirmed the nurse would chart by exception and enter a progress note if a resident exhibited respiratory symptoms. The intent was for the nurse to check SpO2 with the temperature and to document both results in the medical record and not by exception. When interviewed on 4/9/20, at 2:30 p.m. director of nursing (DON) verified and stated, The nurses do the assessments and take vitals and then watch for any cough or reported cough or change in O2 sats (SpO2) or fever or any sort of change of condition. We do documentation by exception. DON further confirmed the temperature and SpO2 should be always be documented, not by exception. DON stated temperature monitoring was originally once a day and changed to twice a day which started about a week ago. For the last week, the expectation was two times a day. Review of random records in PCC indicated no orders for increased frequency of temperature, SpO2 or respiratory symptom monitoring. Conditional q4 hour check orders noted on two residents. Review of temperature documentation under vital signs in PCC for 50 of the 238 residents in the facility, 31 residents (R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31 and R32) lacked a temperature result documented one or more of the seven days from 4/2/20 through 4/8/20. The facility policy Infection Control Surveillance-[MEDICAL CONDITION] (COVID-19) dated April 2020, identified licensed nurses will conduct daily ongoing surveillance of residents for signs and symptoms of COVID-19. The policy directed licensed nursing staff to screen all residents for temperature, pulse, respirations, SpO2, diarrhea and change in condition every day and to document results of screening in the resident's medical record.