Electronically Delivered

May 1, 2023

Licensee
Walker Methodist Care Suites
7400 York Avenue South
Edina, MN 55435

RE: Project Number(s) SL20444015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 22, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20444	A. BUILDING: _____ B. WING _____	03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST CARE SUITES	7400 YORK AVENUE SOUTH EDINA, MN 55435

(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) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20444015 On March 20,2023, through March 22, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 67 active residents; all receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 20, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another	0 630		

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0 630	Continued From page 2 individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for three of five residents (R7, R8, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R7 R7 was admitted September 24, 2021, and resides in licensee's secured memory care unit. R7's diagnosis include, but are not limited to, mild cognitive impairment, unspecified dementia with behavioral disturbance, unspecified fracture of sacrum, constipation, essential (primary) hypertension, hypothyroidism, unspecified osteopenia, personal history of deep vein thrombosis, other abnormalities of gait and	0 630		

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0 630	Continued From page 3 mobility, and other symptoms and signs involving cognitive functions and awareness. R7's Physician Order Sheet dated March 21, 2023, read, "1/18/28 - Divalproex 125mg DR Capsule (Depakote 125mg DR Capsule)- every 1 days, next date on Tue, 3/21/2023-, 1 CAP SPRINK-PO-TAKE 1 CAP BY MOUTH ONCE DAILY FOR AGITATION." Divalproex is a provider ordered medication used to treat the manic phase of bipolar disorder (manic-depressive illness), and to help calm a person when agitated or showing indications of agitation. R7's Vulnerable Adult and Individualized Abuse Prevention Plan Assessment dated February 22, 2023, indicated R7 exhibits behaviors posing a risk to self, (wandering), requiring staff re-orientation throughout the building. R7's Service Plan Agreement dated June 15, 2022, at 12:00 p.m., indicated R7 required Behavior Interventions three times a day beginning on May 20, 2022, and to report abnormal behavior, paranoia, hallucinations, or agitation to the nurse. R7's MAR (medication administration record) dated March 2023, included documentation R7 received R7's Divalproex 125mg DR Capsule daily as prescribed. R8 R8 was admitted September 22, 2016, and resides in licensee's secured memory care unit. R8's diagnosis include, but are not limited to, dementia associated with alcoholism and behavioral disturbance, and encephalopathy.	0 630		

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0 630	Continued From page 4 R8's Physician Order Sheet dated July 8, 2022, read, "7/14/2020 - Escitalopram 20mg TABLET (Lexapro 20mg TABLET)- every 1 days, next date on Fri, 7/8/2022-, 1 TABLET-PO (by mouth), ONCE A DAY-8PM-Indicated FOR depression." Escitalopram is a provider ordered psychotropic medication used to treat anxiety and depression. R8's Vulnerable Adult and Individualized Abuse Prevention Plan Assessment dated March 3, 2023, indicated R8 exhibits behaviors posing a risk to self and others, (inability to identify potentially dangerous situations and inability to cope with/protect self from verbally/physically aggressive persons), requiring staff re-orientation throughout the building. R8's Service Plan Agreement dated January 27, 2023, at 4:00 p.m., indicated R8 required Orientation/Confusion Interventions three times a day beginning on July 8, 2022, to be used when R8 is feeling confused, scared, or unsafe. R8's MAR (medication administration record) dated March 2023, included documentation R8 received R8's Escitalopram 20mg TABLET daily as prescribed. R9 R9 was admitted November 18, 2021, and resides in licensee's secured memory care unit. R9's diagnosis include, but are not limited to, Alzheimer's dementia without behavioral disturbances, essential hypertension, adjustment disorder with depressed mood, nonexudative age-related macular degeneration, osteopenia, hyperlipidemia, and frequency of micturition. R9's Physician Order Sheet dated November 28,	0 630		

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0 630	Continued From page 5 2022, read, "12/16/2021-Olanzapine 2.5mg Tablet (Zyprexa 2.5mg Tablet)- As needed- 1 tablet-PO-Take 1 tablet by mouth once daily as needed for agitation/Anxiety-PRN-Indicated for agitation." Zyprexa is a provider ordered anti-psychotic medication used to treat agitation. R9's Vulnerable Adult and Individualized Abuse Prevention Plan Assessment dated February 10, 2023, indicated R9 exhibits behaviors posing a risk to self and others, (inability to identify potentially dangerous situations and inability to cope with/protect self from verbally/physically aggressive persons). R9's Vulnerable Adult and Individualized Abuse Prevention plan indicates "R9 has been know to collect items that resident's and staff leave out". R9's Service Plan Agreement dated January 24, 2023, at 3:58 p.m., indicated R9 required Behavior Interventions three times a day beginning on May 20, 2022, and to report abnormal behavior, paranoia, hallucinations, or agitation to the nurse. R9's MAR (medication administration record) dated March 2023, included documentation R9 received R9's Olanzapine 2.5mg Tablet daily as prescribed. On March 21, 2023, at 9:30 a.m., while on a tour of resident R7's apartment with unlicensed personnel (ULP)-D, surveyor observed R7's room with seven (7) metal screws, approximately 1" in length in the kitchen cupboard, next to the sink area. R7's door to their room was open to the common area and other residents were moving about the common area without staff in direct line of sight to observe if any resident would enter	0 630		

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0 630	Continued From page 6 R7's room. On March 21, 2023, at 9:40 a.m., while on a tour of resident R8's apartment with unlicensed personnel (ULP)-D, surveyor observed R8's room with one (1) meat fork/kitchen tool, approximately 13" in length in the kitchen, hanging with a spoon set, on the wall above the kitchen counter. R8's door to their room was open to the common area and other residents were moving about the common area without staff in direct line of sight to observe if any resident would enter R8's room. On March 21, 2023, at 9:50 a.m., while on a tour of resident R9's apartment with unlicensed personnel (ULP)-D, surveyor observed R9's room with one (1) scissors unsecured and located in the top kitchen drawer. The scissors appeared to have a 6" cutting blade and commonly used as a kitchen scissors, and one (1) unsecured craft scissors in the bedroom, on a table, in an accessory holder. The scissors appeared to have a 4" cutting blade and commonly used as craft scissors. R9's door to their room was open to the common area and other residents were moving about the common area without staff in direct line of sight to observe if any resident would enter R9's room. On March 21, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A stated, families were informed not to bring sharp objects into resident's rooms, but at times families bring in objects without informing staff. LALD stated sharp objects would be removed from resident's rooms and families would be notified to pick them up. The licensee's Vulnerable Adult Maltreatment Prevention and Reporting Assisted Living policy dated February 25, 2022, indicated resident	0 630		

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0 630	Continued From page 7 abuse prevention plans would include assessment of environmental factors and include specific measures by the licensee to minimize the risk of abuse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside and in the immediate vicinity of all sleeping rooms and failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 20, 2023, at approximately 1:00 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A and the Director of Environmental Services (DES)-F. During the facility tour, survey staff observed that the residents' sleeping rooms were within a suite, and the residents' sleeping room doors were Dutch doors with no fire rating information. During the interview, DES-F confirmed that the Dutch doors were not fire-rated. The sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the suite, so that the actuation of one alarm would cause all alarms to operate. It was also observed that a smoke alarm was not installed outside and in the immediate vicinity of the sleeping rooms within the suite. During the interview, LALD-A and	0 780		

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0 780	Continued From page 9 DES-F confirmed these deficient conditions consistent in all sleeping rooms within every suite. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 10 Findings include: On March 20, 2023, at approximately 1:00 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A and the Director of Environmental Services (DES)-F. During the facility tour, survey staff observed the following items: It was observed that the door was propped open with a rubber wedge in the laundry room on the lower level. The temperature in the room was high, and the room did not have a return air vent. It was also observed that the sprinkler head was rusted and covered in dust in the storage area within the laundry room. During the interview, DES-F stated that the room is extremely hot without proper air circulation, and staff leaves the door open while the equipment is running. It was observed that residents' sleeping rooms are located within a suite, and the suite doors were propped open with magnetic door holders at the bottom of the door. During the interview, DES-F confirmed that the doors are fire-rated doors, and the magnetic door hold was not connected to a building fire alarm system. The door is required to automatically close and latch to maintain the fire barrier from the corridor. During the interview, LALD-A and DES-F also confirmed these deficient conditions consistent in all suite doors. It was observed that the egress stair door from the lower level could not be opened due to rust and sticking to the frame. This stair door was identified as an exit by an overhead exit sign. During the interview, DES-F stated that the replacement door had been ordered.	0 800		

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0 800	Continued From page 11 LALD-A and DES-F visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST CARE SUITES	7400 YORK AVENUE SOUTH EDINA, MN 55435

(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) COMPLETE DATE
0 810	Continued From page 12 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review of the available documentation were conducted on March 20, 2023, at approximately 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A and the Director of Environmental Services (DES)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did have a fire safety and evacuation plan. But during the tour, it was	0 810		

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0 810	Continued From page 13 observed that the posted fire safety and evacuation plans on all four levels were not accurate depictions of the egress route and were not matched to the installed overhead exit signage location. The stair by the community room on the lower level did not have an overhead exit sign, but it was identified as an exit on the posted evacuation plan. The open atrium stair on the second floor did not have an overhead exit sign, but it was identified as an exit on the posted evacuation plan. At the top of the stair, it was observed that the half-height gate was installed, and the gate was locked with a card reader access function. The egress stair connecting the first floor to the third floor by unit C221 was not identified as an exit on the posted evacuation plan. The pair door at the Memory care entrance was not shown in the posted evacuation plan. This deficient condition was visually verified by LALD-A and DES-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record	02310		

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02310	Continued From page 14 review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for four of four (R1, R2, R4, R5) who utilized bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted and started care at the facility on January 10, 2022. R1's diagnoses included, but were not limited to chronic Parkinson's disease, hypertension, Dementia-Alzheimer's disease, trans ischemic attack (TIA), Osteoarthritis, Osteoarthritis, and gastroesophageal reflux disease (GERD). The Uniform Nursing Assessment, dated December 26, 2022, indicated R1 had/was: -incontinent of bladder -hard of hearing -weakness/sensory deficit -assistive equipment which included four-wheeled walker and manual wheelchair -staff physical assist of one to transfer -physical devices to include lift chair and halo or bed cane -intermittent confusion -high risk for fall -cognitive impairment /dementia -difficulty using call system	02310		

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02310	Continued From page 15 The Physical Device Assessment sheet, dated December 27, 2022, indicated R1 had SonderCare bed rails applied to both sides of bed to assist with mobility and transfers due to cognitive decline/dementia, generalized weakness/ debility, weakness of lower extremities, and diagnosis of Parkinson's disease. The assessment indicated the facility did not consider the physical devises to be assistive physical devices. March 21, 2023, at 9:15 a.m., an unlicensed personal (ULP)-E stated R1 required assistance with all activities of daily living (ADLs) including transfers and mobility, was confused but could follow simple direction, was wheelchair bound and incontinent of bowel and bladder. ULP-E explained that although R1 had bilateral bedrails, the rails were not used and were always in the lowered position. On March 21, 2023, at 9:28 a.m., R1's unoccupied bed was observed to have bilateral, half hospital-type bed rails. The rails were in the raised position. R2 was admitted and started care at the facility on December 16, 2020. R2's diagnoses included but were not limited to chronic obstructive pulmonary disease, DM2, hypertension, general weakness peripheral vascular disease disk (various) disorders osteoarthritis, spinal stenosis, generalized muscle weakness. The Uniform Nursing Assessment dated January 13, 2023, indicated R2 had/was: -cognitive impairment/delusions	02310		

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02310	Continued From page 16 -insulin dependent -hard of hearing -assistive equipment including two-wheeled walker -incontinent of urine -intermittent confusion (forgetful, limitations) -high risk for falls -short-term memory impairment /cognitive impairment and delusions -depression/significant anxiety disorder The Physical Device Assessment sheet, dated January 13, 2023, indicated R2 had bed rails applied to both sides of the bed due to generalized weakness and debility. The assessment further stated that although R2 did not use the bed rails, family wanted to continue to use the specialty bed and the "rails would be left in the down position at all times." On March 21, 2023, at 9:45 a.m., R2's unoccupied bed was observed to have bilateral, half hospital-type bed rails in the lowered position. ULP-F stated R2 was independent with transfers and mobility and was able to communicate her needs effectively to staff. On March 21, 2023, at 11:37 a.m., R2 stated the bed rails were not utilized for mobility or transfers. R4 was admitted and started care at the facility on October 17, 2022. R4's diagnoses included but were not limited to dementia, behavioral disturbance, Alzheimer's disease, chronic kidney disease and unspecified mood disorder. R4 resided in the memory care unit.	02310		

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02310	Continued From page 17 The Uniform Nursing Assessment dated January 6, 2023, indicated R4 had/was: -frequent/ recent falls -incontinence of bowel and bladder -hard of hearing -assistive equipment/two-wheeled walker -physical device Halo safety ring -intermittent confusion -high risk for falls -short- and long-term memory impairment -depression/anxiety disorder -self-isolation -history of elopement -unable to use call system -verbal direction -secured environment On March 20, 2023, at 12:30 p.m., during a facility tour with licensed assisted living director (LALD)-A, surveyor noted a halo device applied to the right upper portion of residents bed. in R4's room. The Physical Device Assessment sheet, dated January 6, 2023, indicated R4 had Halo device applied to right side of bed to assist with mobility and transfers due to generalized weakness/ debility. The assessment indicated the facility did not consider the physical devises to be assistive physical devices. On March 20, 2023, at 3:19 p.m., during an interview with registered nurse (RN)-B, RN-B stated licensee imagined that the device had not been checked for recall. R5 was admitted and started care at the facility on February 5, 2021 R5's diagnoses included but were not limited to	02310		

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02310	Continued From page 18	02310		

hypertension, confusion, low back pain, osteoarthritis, bipolar disorder, compression fracture, fatigue, and macular degeneration. R5 resided in the memory care unit.

The Uniform Nursing Assessment dated January 13, 2023, indicated R5 had/was:
- high fall risk / frequent falls (four in past quarter)
-cognitive disfunction
-incontinence of bowel and bladder
-unable to always make needs known
--impaired vision and hearing
-weakness
-Halo type safety ring attached to bed
-utilized cane, walker, wheelchair

On March 20, 2023, at 12:30 p.m., during a facility tour with licensed assisted living director (LALD)-A, surveyor noted a halo device applied to the right upper and left upper portion of residents bed. in R5's room.

The Physical Device Assessment sheet, dated February 16, 2023, indicated R5 had Halo device applied to upper right and left side of bed to assist with mobility and transfers due to poor trunk control and generalized weakness/ debility. The assessment indicated the facility did not consider the physical devises to be assistive physical devices.

On March 20, 2023, at 3:19 p.m., during an interview with registered nurse (RN)-B, RN-B stated licensee imagined that the device had not been checked for recall.

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed

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02310	Continued From page 19 rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail. - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail. - The resident's bed rail use/need assessment. - Risk vs. benefits discussion (individualized to each resident's risks). - The resident's preferences. - Installation and use according to manufacturer's guidelines. - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. The Assisted Living Resources & Frequently	02310		

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02310	Continued From page 20 Asked Questions (FAQs) current recommendations for recall include the following "The United States Consumer Product Safety Commission (CSPC) works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information on its website related to portable bed rail recalls. Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. The licensee's Physical Device- Assisted Living policy created March 4, 2012, and revised March 21, 2023, directed staff to: -install device per manufacturer's guidelines -Check whether the device has been recalled by the CPSC @ https://www.cpsc.gov/Recalls -the Physical Device Assessment will be completed upon move in and initial recommendation, with each 90 day or change of condition assessment -hospital beds were considered medical devices regulated by the FDA and must be used in accordance with: *FDA guidelines: Recommendations for Health Care Providers about Bed Rails /FDA *A Guide to Bed Safety Bed Rails in Hospitals, *Nursing Homes and Home Health Care: The Facts | FDA -consumer and hospital beds *Obtain physician's order for device *Check whether the device had been recalled by the CPSC *Install the device per manufacturer guidelines *Complete measurements of bed device zones	02310		

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02310	Continued From page 21	02310		

to ensure requirements were met per guidelines
-assess whether the device is appropriate for the individual, considering cognitive and physical status
-all physical devices in use would be reviewed during each assessment and care conference to ensure safety and appropriateness for needs.
-devices would be checked for recalls initially, at the 90-day assessment and with a change in condition.

On March 20, 2023, at 2:40 p.m., the director of health services (DHS)-B stated R1 and R2's bed rails were specialty beds and not considered to be hospital type rails or beds. DSH-B further stated that if beds with "consumer rails" were checked for recall status, it was not documented.

On March 20, 2023, at 3:04 p.m. an email message was sent to the SonderCare Bed Company enquiring regarding the status of the Sonder beds in the facility.

On March 21, 2023, at 9:40 a.m., the licensed assisted living director (LALD)-A stated R1 and R2's beds were not hospital beds and were consumer electric beds. LALD-A stated that specific measurements were not obtained or that recalls on consumer beds were verified for any bed in the facility.

On March 23, 2023, at 8:45 a.m., a SonderCare representative responded with an email confirming the SonderCare beds in the facility were certified hospital beds and were approved by the FDA.

No further information was provided.

TIME PERIOD FOR CORRECTION: TWO (2)

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Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *03/20/23*
Time: 14:23:08
Report: 1029231049

Food and Beverage Establishment Inspection Report

Location:
Walker Methodist Care Suites
7400 York Avenue South
Edina, MN55435
Hennepin County, 27

Establishment Info:
ID #: 0038684
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528358351
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils
4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

Large mixer encrusted with food debris. Instructed Candace to have the mixer cleaned and maintained clean. Candace stated that they would be getting rid of the mixer soon.

Comply By: 03/20/23

3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

Wet cloths not in use held in soapy water. Instructed Candace to store wet towels in sanitizer solution if not in use. Corrected during the inspection.

Comply By: 03/20/23

Surface and Equipment Sanitizers

quaternary ammonium: = 400 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

quaternary ammonium: = 400 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

hot water: = at 167 Degrees Fahrenheit
Location: dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: milk
Temperature: 40 Degrees Fahrenheit - Location: server cooler
Violation Issued: No

Process/Item: cooked ground beef
Temperature: 38 Degrees Fahrenheit - Location: walk-in cooler
Violation Issued: No

Process/Item: milk
Temperature: 36 Degrees Fahrenheit - Location: line upright coler
Violation Issued: No

Process/Item: tuna salad
Temperature: 33 Degrees Fahrenheit - Location: line prep cooler
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	1

Conducted inspection of food services area at Walker Methodist Care Suites as part of a Health Regulation Division ("HRD") survey. Inspection was conducted with Candace Hall, Director of Culinary Services and CFPM. All identified issues were discussed with Candace during and after the inspection. Employee illness reporting and exclusion procedures and general food safety were also discussed in addition to sanitizing, and holding temperatures. Foodborne illness causing pathogens were also discussed with an emphasis on antibiotic resistant shigella.

The kitchen and dry storage area were commercial in nature. There was minor water damage observed on the ceiling in the dry storage area. There was also a gap at the floor wall juncture in some of the dry storage.

All identified issues were discussed with Lead HRD Nurse Evaluator, Mary Bruess, RN, after the inspection.

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029231049 of 03/20/23.

Certified Food Protection Manager Candace R. Hall

Certification Number: FM108205 Expires: 08/23/25

Signed: _____

Candace Hall
Director of Culinary Services

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231049

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	1	Date	03/20/23
No. of Repeat RF/PHI Categories Out	0	Time In	14:23:08
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Walker Methodist Care Suites	7400 York Avenue South	Edina, MN	55435	9528358351

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038684		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable COS=corrected on-site during inspection R=repeat violation

Compliance Status		COS	R
Supervision			
1 (IN) OUT	PIC knowledgeable; duties & oversight		
2 (IN) OUT N/A	Certified food protection manager, duties		
Employee Health			
3 (IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 (IN) OUT	Proper use of reporting, restriction & exclusion		
5 (IN) OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 (IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 (IN) OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 (IN) OUT N/O	Hands clean & properly washed		
9 (IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 (IN) OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 (IN) OUT	Food obtained from approved source		
12 IN OUT N/A (N/O)	Food received at proper temperature		
13 (IN) OUT	Food in good condition, safe, & unadulterated		
14 IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 (IN) OUT N/A N/O	Food separated and protected		
16 IN (OUT) N/A	Food contact surfaces: cleaned & sanitized		
17 (IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A (N/O)	Proper cooking time & temperature		
19 IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20 IN OUT N/A (N/O)	Proper cooling time & temperature		
21 IN OUT N/A (N/O)	Proper hot holding temperatures		
22 (IN) OUT N/A	Proper cold holding temperatures		
23 (IN) OUT N/A N/O	Proper date marking & disposition		
24 IN OUT (N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 (IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT (N/A)	Food additives: approved & properly used		
28 (IN) OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. COS=corrected on-site during inspection R= repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41	X	Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls: _____

Person in Charge (Signature) _____ Date: 03/20/23

Inspector (Signature) Samuel McClintock