Electronically Delivered

April 24, 2024

Licensee
Walker Methodist Plaza Cityview
131 Monroe Street
Anoka, MN 55303

RE: Project Number(s) SL30628015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

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. 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 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 MDH within 15 calendar days of the correction order receipt date.

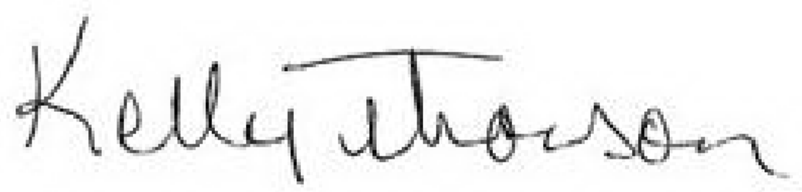
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30628	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLAZACITYVIEW	131 MONROE STREET ANOKA, MN 55303

(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: SL30628015-0 On April 1, 2024, through April 3, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 87 residents; 23 receiving services under the Assisted Living 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.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is	0 100		

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0 100	Continued From page 1 licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when they applied for licensure for their building without having an approved two-hour fire wall separating the public parking garage from the building. 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 the residents). The findings include: During an interview on April 2, 2024, at 10:30 a.m. engineering survey staff requested verification the wall and floor ceiling assembly separating the assisted living from the adjacent public parking garage in the same building was a 2-hr. fire barrier. On April 3, 2024, at 2:44 p.m., engineering survey staff emailed maintenance (M)-H, and maintenance (M)-I, requesting documentation verifying this assisted living is separated from the adjacent public parking garage in the same building by a 2hr fire barrier. No documentation was received based on this request. On April 4, 2024, at 1:05 p.m., engineering survey staff emailed M-H, and M-I, requesting documentation verifying this assisted living is	0 100		

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0 100	Continued From page 3 separated from the adjacent public parking garage in the same building by a 2hr fire barrier. No documentation was received based on this request. On April 5, 2024, at 8:24 a.m., engineering survey staff emailed M-H, and M-I, requesting documentation verifying this assisted living is separated from the adjacent public parking garage in the same building by a 2hr fire barrier. On April 8, 2024, at 9:17 a.m., engineering survey staff received structural building drawings that did not indicate fire resistant ratings of the separation between this assisted living and the adjacent public parking garage within the same building. On April 11, 2024, 7:48 a.m., engineering survey staff received an email update from M-I that M-H had reached out to the City of Anoka for the requested drawings and M-H was waiting for a response. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680		

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0 680	Continued From page 4 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, 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). The findings include: The licensee's emergency disaster preparedness	0 680		

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0 680	Continued From page 5 plan lacked evidence of the following required content: - emergency officials contact information which included state licensing and certification agency and Minnesota office of ombudsman for LTC (OOLTC). On April 1, 2024, at 2:02 p.m., director of operations (DO)-E verified emergency preparedness plan lacked the content listed above and stated they were unaware of the requirement. The licensee's undated Crosswalk: Appendix Z with Emergency Preparedness Program at Walker Methodist policy indicated the EPP would be aligned with federal, state, and local emergency plan (EP) requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 780		

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0 780	Continued From page 6 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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected and hardwired smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, 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) 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 of the residents). Findings include: Interconnection On a facility tour on April 2, 2024, at 10:45 p.m., with maintenance (M)-H, and maintenance (M)-I, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms in the dwelling and sleeping	0 780		

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0 780	Continued From page 7 units throughout the facility. Smoke alarms were tested within each dwelling and sleeping unit entered during the survey and none of the alarms were interconnected. All dwelling and sleeping units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling or sleeping unit. During the tour the smoke alarms were tested and M-H, and M-I, stated the smoke alarms were not reprogrammed to be interconnected so activation of one alarm activates all alarms throughout the facility when batteries were replaced. Power Supply During the same tour it was observed that smoke alarms receiving power from the building electrical system were replaced with alarms with battery power only. Existing alarms receiving power from the building electrical system that are replaced are required to continue receiving power from the building electrical system in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. Additional battery-operated alarms installed where power was not previously provided by the building electrical system, are required to be interconnected with the alarms powered by the building electrical system. During the tour M-H, and M-I, verified the existing hardwired smoke alarms were not powered by the building electrical system and were battery power only alarms.	0 780		

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0 780	Continued From page 8 TIME PERIOD FOR CORRECTION: Two (2) day.	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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, 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: On a facility tour on April 2, 2024, at 11:00 a.m., with maintenance (M)-H and maintenance (M)-I, the surveyor made the following observations of	0 800		

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0 800	Continued From page 9 facility hazards and disrepair: Holes were observed in the fire-resistant rated ceiling membrane in the server room, and utility room on 4th floor. The membrane of fire-resistant rated floor ceiling assemblies is required to be maintained in place and sealed as designed and installed at the time of construction approval, according to Minnesota Fire Code in Minnesota Rules Chapter 7511. Water damage near the center stairway and holes were observed in the drywall portion of the ceiling in the second floor of public parking garage. The membrane of fire-resistant rated floor ceiling assemblies is required to be maintained in place and sealed as designed and installed at the time of construction approval, according to Minnesota Fire Code in Minnesota Rules Chapter 7511. Light fixture covers were missing on the drywall portion of the ceiling on the second floor of the public parking garage. Ceiling light fixtures are required to be maintained with all covers and guards in place according to the product manufactures instructions. Door closers were removed from fire-resistant rated corridor doors in resident rooms 105, 223 and 305. During the tour M-H and M-I stated several closers have been removed from fire resistant rated doors throughout the facility. Fire-resistant rated doors are required to be maintained self-closing and latching as designed and installed at the time of construction approval, according to Minnesota Fire Code in Minnesota Rules Chapter 7511. The fire-resistant rated doors of all laundry rooms	0 800		

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0 800	Continued From page 10 were held open with a device that was not automatic closing upon activation of the fire sprinkler, fire alarm system or loss of power to the building. Fire-resistant rated doors are required to be automatically self-closing and latching upon activation of the building fire protection systems or loss of power, according to Minnesota Fire Code in Minnesota Rules Chapter 7511. The fire-resistant rated doors in the exit stairway near resident rooms 321 and 205 did not positively latch. Fire-resistant rated doors are required to automatically close and latch in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. During a facility tour on April 2, 2024, at 12:00 p.m., M-H and M-I, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910		

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0 910	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R6, R9, R10). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: The licensee began providing services under their assisted living facility license on August 1, 2021. R6 R6 admitted to the licensee on July 23, 2022, and began receiving assisted living services. R6's medical record included a Resident Agreement signed August 4, 2022. R9 R9 admitted to the licensee on September 17, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R9's medical record included a Resident Agreement signed August 17, 2022. R10 R10 admitted to the licensee March 29, 2021,	0 910		

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0 910	Continued From page 12 under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R10's medical record included a Resident Agreement signed July 27, 2021. R6, R9, and R10 written contracts lacked the following required content: - the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. On April 3, 2024, at 7:49 a.m., licensed assisted living director (LALD)-A stated the licensee updated their contract to include the HFID number on November 15, 2023. LALD-A stated they believed residents who were provided the previous contract would not have been issued a new contract but would have been provided an update of the contract. LALD-A stated residents were provided contract updates yearly. LALD-A stated they needed contact another employee to see if the updates were sent to R6, R9, and R10. On April 3, 2024, at 10:57 a.m., director of operations (DO)-E stated contracts issued prior to May 26, 2021, would not have the license number or the HFID because the licensee did not know the numbers at the time the contracts were issued. DO-E stated a notification was sent out to all residents who resided in the facility when the licensee's license number changed however, it did not include the HFID. In addition, DO-E stated they did not have record who received the notification. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30628	A. BUILDING: _____ B. WING _____	04/03/2024

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0 910	Continued From page 13 (21) days	0 910		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be	01730		

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01730	Continued From page 14 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of three residents (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R9 admitted to the licensee on September 17, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R9's diagnoses included anemia, spinal stenosis, diverticulitis of intestine, fracture of the left femur, depression with anxiety, hypertension, irritable bowel syndrome, ad sleep disorder. R9's Service Plan Agreement signed March 7, 2024, included bathing, escort to meals, dressing,	01730		

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01730	Continued From page 15 housekeeping, and complex medication administration. In addition, the registered nurse (RN) would coordinate with providers for orders, changes and refills, all medications would be kept in a durable locked medication cart, medication administration would be completed by a licensed nurse or delegated to an unlicensed personnel (ULP), and ULP would notify the nurse if any problem arouse with medication management. On April 2, 2024, at 8:46 a.m., the surveyor observed ULP-D prepare R9's medications. The surveyor did not observe a location for lidocaine patch four percent (%) to be applied to R9 in the electronic medication administration record (EMAR). The surveyor inquired where R9's lidocaine patch would be applied. ULP-D stated they could ask R9 were to apply the patch however, they have been applying the lidocaine patch to the lower back for "along time." ULP-D stated the EMAR did not give them specific instructions on where to apply the lidocaine patch. On April 2, 2024, at 8:55 a.m., the surveyor observed ULP-D apply a lidocaine patch to R9's lower back. R9's Medication Administration Record dated April 1, 2024, through April 30, 2024, included lidocaine pain patch four % "apply one patch to clean dry intact skin once daily. Leave on for up to 12hrs/24hrs." R2's medication management plan comprised of multiple documents lacked the following: - documentation of specific resident instructions related to the administration of medications. On April 3, 2024, at 8:04 a.m., clinical nurse supervisor (CNS)-B stated resident specific	01730		

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01730	Continued From page 16 instructions for medications should be written in the EMAR. CNS-B verified the lidocaine for R9 did not have specific instruction listed in the EMAR and stated it was an oversite that specific instructions were not written for the lidocaine patch. The licensee's Medication Management Services policy dated June 25, 2021, indicated a individualized medication management record for each resident, based on the resident's assessment would include documentation of specific resident instructions relating to the administration of medication. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of four residents (R6). 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	01830		

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01830	Continued From page 17 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 admitted for services on July 23, 2022. R6's Service Plan dated February 16, 2024, indicated R6 received services to include medication administration. R6's April 2024, medication administration record showed the following medications: -levothyroxine 75mcg -mupirocin 2% topical ointment -Eliquis 5mg -metformin 500mg -potassium cl 20meq ER -psyllium fiber capsule -sotalol 80mg -spironolactone 25mg -vitamin D3 2000iu -furosemide 40mg -rosuvastatin 40mg -triple antibiotic ointment -acetaminophen 500mg R6'2 record showed signed orders for metformin, levothyroxine, and potassium dated March 20, 2023. On April 3, 2024, at 10:55 a.m., clinical nurse supervisor (CNS)-B stated they did not have current signed provider orders for metformin, levothyroxine, and potassium. CNS-B further stated there had been a lot of changes in nursing and management and it was missed.	01830		

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01830	Continued From page 18 The licensee's Medication Management Services policy revised June 25, 2021, indicated a current written provider's prescription must be obtained for any prescription medication. Prescriptions must be renewed every 12 months or more frequently, as indicated by the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for three of 11 residents (R1, R2, R3). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01890		

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01890	Continued From page 19 found to be pervasive). The findings include: On April 1, 2024, at 10:20 a.m., the surveyor observed two medication carts containing medications for residents located on the first through fourth floor and observed the following expired medications: - R1 loperamide 2 mg with a date filled September 15, 2022; - R2 Zofran 4mg with and expiration date of November 24, 2023; and - R3 two bottles of nystatin 100,000 units/gram (IU/GM) expired on February 25, 2024. Registered Nurse (RN)-C stated the licensee used multiple pharmacies and some labels did not include an expiration date however, the pharmacy said medications expired one year after the date filled. RN-C stated all staff were trained to dispose of medications one year after medications were filled. On April 1, 2024, at 10:51 a.m., RN-C stated they conducted monthly audits on each medication cart where they would remove medications that was no longer in use or expired. RN-C stated the last medication cart audit was conducted in February 2024. RN-C stated medications that were expired would be disposed of and documented on. RN-C stated R1, R2, and R3's expired medications were not removed during the last audit and were missed because they read the prescription labels to quick. The licensee's Medication Management Services dated June 25, 2021, the licensee shall dispose of any medications that are remaining that are discontinued, expired or upon the termination of	01890		

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01890	Continued From page 20 the service contract or the resident's death, according to state regulations for disposition of medications and controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	01940		

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01940	Continued From page 21 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R10) who received treatments. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R10 admitted to the licensee March 29, 2021, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R10's diagnoses included mixed anxiety disorder, type two diabetes with out complications, obstructive sleep apnea, coronary artery disease, hypertension, Parkinson's disease, and spinal stenosis (narrowing of the spinal column that compresses the spinal cord) the lumbar region. R10's Service Plan Agreement policy signed January 2, 2024, indicated R10 received assistance with weight monitoring, blood glucose checks every four weeks on Monday,	01940		

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01940	Continued From page 22 Wednesday, and Friday, and complex medication administration. In addition, the service plan included a portion of the treatment management plan that was not individualized to R10 and read, "treatment and Therapy Management services will be provided by the community as ordered by a licensed professional or medical provider. The types of treatment and/or therapy, as well as any specific instructions for the resident, will be noted in the services. Treatments and therapies will be provided by a licensed nurse or may be delegated to unlicensed personnel (ULP) that have been trained and deemed competent to perform the task. The ULP will be trained and directed to document when a treatment or therapy is or is not provided and to notify a nurse if there are any problems or concerns." R10's prescriber order dated February 1, 2024, included blood glucose monitoring every four weeks on Monday, Wednesday, and Friday. R10's Medication Administration Record (MAR) dated March 1,2024, through March 31, 2024, included blood glucose monitoring check blood sugar every morning Monday, Wednesday, and Friday one time per month. The MAR lacked parameters on when to call a health care professional if blood glucose levels were too high or low. R10's Medication Administration Record (MAR) dated April 1,2024, through April 30, 2024, included blood glucose monitoring check blood sugar every morning Monday wed and Friday one time per month. The MAR lacked parameters on when to call a health care professional if blood glucose levels were too high or low. R10's treatment management plan comprised of	01940		

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01940	Continued From page 23 multiple records lacked an individualized treatment and therapy record that contained procedures for notifying a registered nurse or appropriate licensed health professional when a problem arouse with the treatment or therapy service. On April 3, 2024, 8:07 a.m., clinical nurse supervisor (CNS)-B stated the believed parameters for when to contact a nurse if blood glucose levels where too high or low would be listed on the MAR. CNS-B stated they would need to verify that with another coworker. On April 3, 2024, at 10:03 a.m., CNS-B stated ULP were trained on when to contact a nurse for blood glucose levels during orientation and the licensee had a document that contained different resident concerns and when the ULP should contact the registered nurse (RN) located in the health service office and the medication carts. The surveyor inquired if they had anything individualized to R10. Regional director of clinical services (RDOCS)-G stated ULP would follow document for when to contact a nurse however, if the resident had different parameters than what was listed on the document than it would be written in the medical record. On April 3, 2024, via email correspondence at 10:23 a.m., RDOCS-G provided the surveyor with a document titled Resident Condition and When to Call dated August 8, 2016, indicated staff were to notify a on call RN when blood glucose levels were below 70 or over 200 and it was an emergency call to 911, RN, and family when blood glucose levels were below 30 or above 400. The licensee's Treatment and Therapy Management Services policy dated July 27, 2021,	01940		

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01940	Continued From page 24 indicated an individualized treatment or therapy management record would be developed and maintained for each resident and would include the following: - a written statement of the type of services provided in the service plan; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to ULP; - procedures for notifying a RN or appropriate licensed professional when a problem arises with treatment or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatments and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *04/01/24*
Time: 12:10:27
Report: 1051241003

Food and Beverage Establishment Inspection Report

Location:
Walker Methodist Plazacityview
131 Monroe Street
Anoka, MN55303
Anoka County, 02

Establishment Info:
ID #: 0039331
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634537125
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.

No NEW orders were issued during this inspection.

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

THE FACILITY WAS INSPECTED BY TREVOR MCCLIMENT (MDH) AND KAI YANG (MDH).

MET UP WITH NURSE SURVEYOR, WENDY ROBARGE.

NO FOOD SERVICE IS SERVED IN THIS FACILITY.

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 1051241003 of 04/01/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us