STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walker Methodist Westwood Ridge II	61 Thompson Avenue West West Saint Paul, MN 55118

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate monitoring and documentation related to psychotropic medication use to include side effect monitoring and resident-specific target behaviors for 3 of 5 residents (R3, R25 and R42) reviewed for unnecessary medications. R3's face sheet dated 4/16/26, indicated R5 was admitted to the facility on [DATE]. R3's admission Minimum Data Set (MDS) dated [DATE], indicated R3 was cognitively intact and had diagnoses of schizophrenia and anxiety. R3's Order Summary Report dated 4/16/26, included the following orders: Buspirone (antianxiety medication) HCL 5 milligrams (mg), take 2 tablets, three times a day for schizoaffective disorder. Risperidone (an antipsychotic used to treat schizophrenia) 0.5 mg, take 1 tablet twice a day po for schizophrenia. Clozapine (an antipsychotic medication) 100 mg, take 400 mg once a day for schizoaffective disorder. Venlafaxine (an antidepressant medication) HCL ER oral capsule 24-hour relief, take 75 mg capsule every day for anxiety associated with depression. Venlafaxine HCL ER 150 mg po, take with 75 mg dose every day for anxiety associated with depression. R3's care plan and medication/treatment administration record (MAR/TAR) lacked documentation of specific target behaviors for her psychotropic medications (substances that affect mood, emotions, thoughts, and behavior by targeting brain neurotransmitters like serotonin, dopamine and norepinephrine) use. During interview on 4/15/26 at 8:37 a.m., director of nursing (DON) stated the nurses monitored the residents for side effects to psychotropic medications, and the nursing assistants (NAs) documented behaviors under tasks. The behaviors tasks included generic behaviors, and it was part of the NAs documentation for all residents. The DON stated target behaviors needed to be monitored. DON added, on admission the social worker reviewed the admission orders, diagnoses, checked the residents' social history and identified target behaviors. The target behaviors should be included in the residents' care plan and should also be included in the MAR/TAR. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25 R25's face sheet, printed 4/15/26, indicated R25 was originally admitted to the care center on 3/16/26 with a readmission on [DATE]. R25's orders indicated an order, dated 3/31/26, for Venlafaxine (an antidepressant medication) 75 milligrams (mg) once a day for moderate episodes of recurrent major depressive disorder. R25's electronic medical record, including the medication and treatment administration record, orders and care plan, lacked evidenced of documented and resident specific target behaviors for psychotropic medication (substances that affect mood, emotions, thoughts, and behavior by targeting brain neurotransmitters like serotonin, dopamine, and norepinephrine. Major classes include antidepressants) use. During an interview on 4/14/26 at registered nurse (RN)-B target behaviors did not show up on the MAR/TAR and nursing aides (NA) have a place where they document resident behaviors. A generic task, the same for all residents, for the NAs to document behaviors such as yelling/screaming, rejection of care, threatening behaviors, wandering, kicking/hitting, frequent crying, etc. R42 R42's face sheet, printed 4/15/26, indicated R42 was admitted to the care facility on 4/6/26. R42's Orders indicated an order, dated 4/6/26 for Mirtazapine (an antidepressant medication) 7.5 mg once a day at bedtime. The order lacked a specific indication for use, however R42's EMR indicated a diagnosis of generalized anxiety disorder, dated 2/8/25. R42's electronic medical record (EMR), to include the medication and treatment administration record, active orders and care plan lacked evidence that R42's was being monitored for side effects of antidepressant (psychotropic) medications which can include drowsiness, dizziness, constipation, and dry mouth. During an interview on 4/14/26 at 10:03 a.m., registered nurse (RN)-B stated that medication side effect monitoring should show up on each residents' medication and treatment administration record to be documented on every shift. During an interview on 4/14/26 at clinical coordinator and licensed practical nurse (LPN)-A confirmed R42 did not have any medication side effect monitoring in place and that it would be expected. LPN-A also confirmed R25 only had generic task target behaviors in electronic medical record and that it would be expected that nurses would document any resident behaviors in a progress note. During an interview on 04/15/2026 at 8:36 AM, the director of nursing (DON) stated that side effect monitoring is focused more closely on high-risk medications. This monitoring is incorporated into the care plan, with specific elements added to the kardex for aides to observe. The DON explained that psychotropic medications, such as antidepressants, should be monitor for side effects. The DON further stated social services was responsible for reviewing resident referrals and generating resident specific target behaviors in the residents' electronic medical records when they were receiving psychotropic medications. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Psychotropic Medication, dated 11/1/25, indicated nurses would document the resident's response, adverse effects, and effectiveness in the medical record.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure written discharge/transfer notices were given as soon as practicable for 1 of 1 residents (R35) reviewed for hospitalization and 1 of 2 residents (R2) reviewed for discharge. In addition, the facility failed to ensure the written notice of transfer included a statement of the resident's appeal rights and the name, address, and telephone number of the entity that receives appeal requests for 1 of 1 residents (R35) reviewed for hospitalization.Findings include:R2R2's admission Minimum Data Set (MDS) assessment, dated 3/3/26, indicated R2 had intact cognition with no hallucinations, delusions, or behaviors.R2's Census information dated 2/25/26, indicated R2 was admitted to the facility on [DATE] and discharged on 4/3/26.R2's care conference note dated 3/5/26, indicated R2 would return to his assisted living facility upon discharge and would receive home health services. The note indicated R2 received intravenous antibiotics until 4/2/26, and R2 may stay in the skilled facility until the end of the antibiotic course.R2's progress note dated 4/3/26 at 1:11 p.m., indicated R2 had discharged with his son to an independent living facility.R2's medical record was reviewed and did not indicate that R2 had received a written facility discharge notice, including information such as the ombudsman contact information and information regarding facility discharge appeal rights and resources.R35R35's admission MDS dated [DATE], indicated R35 had moderately impaired cognition with no hallucinations, delusions, or behaviors.R35's Census information dated 1/22/26, indicated R35 was admitted to the facility on [DATE] and transferred to the hospital on 2/5/26.R35's progress note dated 2/5/26 at 8:38 p.m., indicated R35 was transferred to the emergency department for a peripherally inserted central catheter (PICC) replacement and was transported by his wife. R35's Notice of Resident Transfer/discharge date d 2/6/26, indicated R6 was transferred to an emergency department for a PICC replacement. The notice indicated that if the resident needed help obtaining an appeal or other assistance related to the form, the director of nursing (DON) or nursing clinical coordinator could be contacted and included their phone numbers. The notice included a page titled Advocacy and included various phone numbers and addresses, including Medicare Beneficiary and Family Centered Care Quality Improvement Organization, Mid-Minnesota Legal Aid/Minnesota Disability Law Center, the Office of Ombudsman for Long-Term Care and for Mental Health and Developmental Disabilities, and Senior Linkage Line. The form did not include a statement indicating what the resident's appeal rights were, and the name, address, and telephone number of the entity that receives appeal requests. The form was signed by a social services staff member with a date of 2/7/26 and had a blank for a signature acknowledging the receipt of the notice of transfer or discharge with R35's name printed and a date of 2/6/26.During an interview on 4/14/26 at 9:48 a.m., registered nurse (RN)-A stated that if a resident was transferred to the hospital, she would send the necessary medical records along with a bed hold form. RN-A stated she was not aware of the need to send a transfer notice. RN-A stated that after the resident transferred, she would document in a progress note that these documents had been sent with the resident. During an interview on 4/14/26 ay 9:55 a.m., licensed practical nurse (LPN)-A, the clinical coordinator for the facility, stated she had packets prepared for resident transfer that included a notice of transfer/discharge and a bed hold form that she would expect the nursing staff to fill out, upload a copy of to the medical record, and then give to the resident on transfer. At 10:02 a.m., LPN-A stated that social services staff (SS)-A would be a better resource for questions regarding discharge notices. During an interview on 4/14/26 at 10:03 a.m., social services coordinator (SS)-A stated R2 was staying at the facility related to extended intravenous medication use with a known end date. SS-A stated that the facility had known the number of days left of R2's antibiotic use the whole time and had verbally told him his discharge date . SS-A stated she was not aware that a written notice of discharge had to be given, so she did (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not believe one had been. During an interview on 4/14/26 at 12:37 p.m., R2 stated he could not recall if a written notice of discharge had been provided before discharging from the facility.On 4/14/26 at 12:45 p.m., a call was attempted to R35 with no answer.During an interview on 4/14/26 at 2:27 p.m., the DON stated that she had talked with facility staff, and R35's notice of transfer was not given on transfer but was verbally reviewed with the resident at a later date. The DON stated she would expect staff to provide the form to the resident or resident representative on transfer. On 4/15/26 at 8:21 a.m., the DON stated that when someone was discharged , staff would complete a recapitulation of the resident's stay that was given to the resident and signed on discharge. The DON stated that facility staff would also give the resident a Notice of Medicare Non-Coverage, but giving a written facility discharge notice as soon as a discharge date was known was not part of their process.The facility's Discharge and Transfer policy dated 4/1/26, indicated that discharge and transfers will comply with federal regulations, including providing the required written notice. The policy indicated that the written notice would include the applicable appeal rights.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure baseline care plans were in place for 2 of 5 residents (R25, R50) reviewed for baseline care plans. Findings include: R25 R25's face sheet, printed 4/15/26, indicated R25 was originally admitted to the care center on 3/16/26 with a readmission on [DATE]. R25 progress note, dated 3/28/26 indicated R25 was scheduled to discharge home that day, however, was sent to the emergency room for continued pain after a fall and was diagnosed with a pubic bone fracture. The note indicated R25 did not hold her bed at the facility. R25's progress note, dated 3/30/26, indicated R25 readmitted to the care facility after being hospitalized for a pubis and sacral bone fracture post fall. R25's entire care plan, was initiated and dated 4/13/26. R25 had a completed care plan that was canceled on 4/6/26. During an interview on 04/14/2026 at 2:28 PM, the director of nursing (DON) stated the minimum data set (MDS) nurse stated that the process is believed to occur automatically when a discharge/return not anticipated MDS is completed. The resident went out on the 28th and returned on the 30th; the MDS was entered as a return not anticipated. The DON further stated that if a facility does not choose to hold a resident's bed, a full new admission must be completed upon return, which would include a baseline care plan. R50 R50's Tracking record indicated R2 had been admitted to the facility on [DATE]. R50's clinical admission assessment dated [DATE], included a section titled Care Planning with subtitles, such as documented safety concerns, gastrointestinal, behavioral management, risk for disturbed sensory perception, impaired social interaction, new onset weakness, new onset dizziness, pain, pressure ulcers, documented resident/representative concerns, etc. The subtitles then had boxes next to them with goals and interventions that could be checked, but all the boxes were left blank. During email communication on 4/14/26 at 8:05 a.m., R50's baseline care plan was requested from the director of nursing (DON). A care plan formed before the survey entrance was not received. R50's medical record was reviewed and did not include a baseline care plan that was developed within 48 hours after admission (to include information such as the resident's initial goals of care, immediate safety needs, social services needs, etc.) During an interview on 4/14/26 at 9:51 a.m., registered nurse (RN)-A stated that when she admitted a resident, she would complete an admission assessment, but social services or the clinical coordinator would have more information on how the baseline care plan was formed, as she was unsure. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/14/26 at 1:47 p.m., licensed practical nurse (LPN)-A, the clinical coordinator, stated that the facility's electronic health record (EHR) had recently had an upgrade that changed the way care plans were activated. LPN-A stated on the survey entrance, that they had noticed that some residents did not have baseline care plans completed. LPN-A stated that when nursing completed their admission assessment, this should have also triggered the baseline care plan to be formed, but it didn't look like this information from the assessment had been pulled over to the baseline care plan. During an interview on 4/15/26 at 8:25 a.m., the director of nursing (DON) stated that when nursing completed their admission assessment, there were boxes that should have been checked to trigger the residents' baseline care plans, but that did not happen for some residents. The DON stated additional education was needed for nursing staff, so she scheduled a meeting with the staff for tomorrow. The DON stated that she expected the baseline care plan to be formed within 48 hours. The DON stated she would expect this to include the resident's immediate care needs, safety risks, and preferences. Care and Service Plans dated 3/1/26, indicated that baseline care plans would be developed within 48 hours of admission, which would identify the minimum necessary interventions to address immediate care needs, safety risks, and preferences. The policy indicated the baseline care plan would address initial goals based on the admission assessment, identified risks and safety needs, orders and immediate interventions, resident preferences, and advance directives.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision during meals for 1 of 1 residents (R42) with a known swallowing impairment who had a physician order for supervision related to holding food in the oral cavity (pocketing), and who was left unsupervised during meals despite documented risks. Findings include:R42's face sheet indicated R42 was admitted to the care facility on 4/6/26 with a primary diagnosis of pleural effusion. R42's nutrition screen, dated 4/8/26, indicated R42 was on a regular diet with regular textured foods and thin liquids. The screening further indicated that R42 could not use a straw because of a past stroke and would self-select soft foods.R42's progress note, dated 4/8/26 indicated R42 was noted to have food resident in her mouth at 7:22 p.m., and R42 required help eating due to spilling food on the floor. R42's diet order, dated 4/13/26, indicated R24 was to receive a minced and moist texture diet and required supervision while eating. R42's orders also directed staff to perform oral care after oral intake and speech therapy to eval and treat swallow and cognition, also dated 4/13/26. R42's speech therapy orders, dated 4/13/26, indicated R42's diet change to minced and moist and for supervision with meals d/t [due to] food remaining in oral cavity.Kardex, printed 4/14/26, indicated R42 required supervision with eating.During observation on 4/13/2026 at 12:21 p.m., R42 was eating lunch alone in her room. R42 demonstrated prolonged chewing with delayed swallow and was noted to hold food in oral cavity (pocketing). Drooling was observed throughout meal. During continuous observation on 4/14/26 from 12:21 p.m. to 12:31 p.m., R42 received her lunch tray and was observed eating unsupervised.During an interview on 4/14/26 at 12:45 p.m., nursing assistant (NA)-A stated staff had access to Kardex information directing resident care and acknowledged R42 required supervision due to pocketing of food. However, NA-A described supervision as checking on the resident every hour or so.During an interview on 4/14/25 at approximately 2:00p.m., clinical coordinator and licensed practical nurse (LPN)-A stated a referral for speech therapy was received from the nurse practitioner yesterday (4/13/26) and the speech therapy evaluation was completed the same day. LPN-A confirmed awareness of the supervision order but described it as periodic checks and was unable to define the frequency. LPN-A further stated the resident was not considered a choking risk despite documented pocketing. During an interview on 4/14/26 at 3:18 p.m., the director of therapy stated the speech therapist (ST)-A was recommending full supervision with meals due to R42 holding solids in her mouth at all times, stating R42 had not only swallowing issues but cognition issues as well. The DOT stated nursing staff may need more education on what supervision with meals meant and why it was implemented. During an interview on 4/15/26 at 9:26 a.m., ST-A stated her order for R42 to be supervised with meals was intended to ensure staff were present during meals for R42's safety due to pocketing of foods. ST-A stated she would clarify the order to ensure R42 received adequate supervision.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure implementation of medication side effect monitoring for 1 of 1 resident (R42) reviewed for anticoagulant use with a known risk of bleeding. Findings include: R42's face sheet, printed 4/15/26, indicated R42 was admitted to the care facility on 4/6/26. R42's Diagnoses, dated 1/31/25, indicated R42 had a diagnosis of unspecified atrial fibrillation. R42's Orders, indicated an order, dated 4/6/26, for Eliquis (a blood thinning/anticoagulant medication) 2.5 milligram (MG) two times a day. The most common serious side effect is bleeding (i.e., gum, nose, urine, or stools). R42's electronic medical record (EMR), to include the medication and treatment administration record, active orders and care plan lacked evidence that R42's was being monitored for side effects of anticoagulation medication. During an interview on 4/14/26 at 10:03 a.m., registered nurse (RN)-B stated that medication side effect monitoring should show up on each residents' medication and treatment administration record to be documented on every shift. During an interview on 4/14/26 at clinical coordinator and licensed practical nurse (LPN)-A confirmed R42 did not have any medication side effect monitoring in place and that it would be expected. During an interview on 04/15/2026 at 8:36 AM, the director of nursing (DON) stated that side effect monitoring is focused more closely on high-risk medications. This monitoring is incorporated into the care plan, with specific elements added to the kardex for aides to observe. The DON explained that anticoagulants are monitored for signs of bleeding or bruising. A facility policy on side effect monitoring was requested and not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to implement and ensure adherence to infection prevention and control practices, including appropriate use of personal protective equipment (PPE) and proper cleaning and disinfection of shared equipment for residents on contact precautions. This deficient practice placed 2 of 2 residents (R49 and R50) observed on contact precautions at increased risk for the transmission of infectious organisms. Findings include:R49's face sheet, printed 4/15/26, indicated R49 was admitted to the care facility on 4/8/26, and was on contact precautions for a history of Extended-Spectrum Beta-Lactamases (ESBL) (enzymes produced by certain bacteria that make them resistant to a variety of commonly used antibiotics).R50's face sheet, printed 4/15/26, indicated R50 was admitted to the care facility on 4/9/26, and was on contact precautions for methicillin-resistant Staphylococcus aureus (MRSA) (a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). During an observation on 4/15/26 at 7:39 a.m., Licensed Practical Nurse (LPN)-B was present on the unit providing care and administering medications to R49 on contact precautions. Isolation signage on R49's door directed staff and providers to don gloves and gown prior to room entry, use dedicated or disposable equipment and disinfect reusable equipment after use. However, staff demonstrated inconsistent adherence to these precautions. Certified Nursing Assistant (CNA)-B was observed entering the room without personal protective equipment (PPE) to obtain R49's weight. LPN-B also entered R49's room to obtain vital signs, including applying a blood pressure cuff directly to the resident's arm without gloves, scanning the resident's forehead for temperature, and placing an oximeter on the resident's finger, all without use of PPE. During conversation, CNA-B stated she believed PPE was only required during personal care activities and not for tasks such as vital signs or weights. Additionally, LPN-B stated staff were unsure when to utilize gowns and gloves and expressed confusion regarding the difference between enhanced barrier precautions and contact precautions.During a subsequent observation on 4/15/26 at approximately 8:10 a.m., LPN-B was observed transporting a vital signs (VS) tower from R49's room, who was on contact precautions, directly into the room of R50, who was also on contact precautions, without cleaning or disinfecting the equipment between uses. This was inconsistent with isolation signage and infection control practices requiring the use of dedicated equipment or appropriate disinfection of reusable equipment between residents.During an interview on 4/15/26 at 8:36 a.m., the Director of Nursing (DON) and infection preventionist (IP) stated staff were expected to follow the isolation signage, which required the use of gown and gloves when entering a room for residents on contact precautions and cleaning of vital sign equipment with bleach between uses. The DON acknowledged this had been identified as an area needing improvement during a recent mock survey and reported that staff had received retraining on these infection control practices.A facility policy titled Transmission-Based Precautions, dated 1/1/26, indicated when a resident was on contact precautions, staff should wear gloves and a gown upon room entry when contact with infectious material is anticipated and dedicate equipment when able or disinfect prior to use with other residents,