DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0K40

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00829

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245320**

2.STATE VENDOR OR MEDICAID NO.
(L2) **679736900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODLYN HEIGHTS HEALTHCARE CENTER**
(L4) **2060 UPPER 55TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

4. TYPE OF ACTION: **7**

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/01/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, HFE NE II — 02/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/31/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/06/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/09/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245320
March 31, 2017

Ms. Emily Jenkins, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, MN 55077

Dear Ms. Jenkins:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 21, 2017 the above facility is certified for or recommended for:

99 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 99 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 21, 2017

Ms. Emily Jenkins, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, MN 55077

RE: Project Number S5320028

Dear Ms. Jenkins:

On February 2, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 12, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 21, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 12, 2017, effective February 21, 2017 and therefore remedies outlined in our letter to you dated February 2, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 21, 2017

Ms. Emily Jenkins, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, MN 55077

RE: Project Number F5320026

Dear Ms. Jenkins:

On February 3, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 26, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 10, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 26, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 26, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 26, 2017, effective March 10, 2017 and therefore remedies outlined in our letter to you dated February 3, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245320 Y1	A. Building B. Wing Y2	3/1/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278	Correction	ID Prefix F0279	Correction	ID Prefix F0280	Correction
Reg. # 483.20(g)-(j)	Completed	Reg. # 483.20(d);483.21(b)(1)	Completed	Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	02/21/2017
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0323	Correction
Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24, 483.25(k)(l)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed
LSC	02/21/2017	LSC	02/21/2017	LSC	02/21/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 03/21/2017	SIGNATURE OF SURVEYOR 37010	DATE 03/01/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/12/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245320	A. Building 01 - MAIN BUILDING 01 B. Wing	3/10/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 03/10/2017	ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 03/10/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 03/21/2017	SIGNATURE OF SURVEYOR 37010	DATE 3/10/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/26/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0K40

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00829

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245320**

2.STATE VENDOR OR MEDICAID NO.
(L2) **679736900**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODLYN HEIGHTS HEALTHCARE CENTER**
(L4) **2060 UPPER 55TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/12/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Momodou Fatty, HFE NE II — 02/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/09/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/09/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 2, 2017

Ms. Emily Jenkins, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, MN 55077

RE: Project Number S5320028

Dear Ms. Jenkins:

On January 12, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 21, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 12, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 12, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	**2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 278		2/21/17

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

Electronically Signed | 02/10/2017

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F 278	Continued From page 1 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 20 residents (R56 and R69) reviewed for MDS accuracy. Findings include: R56 was observed on 1/11/17, at 8:40 a.m. eating breakfast in bed. The food was mostly pureed diet, but the toast was regular. R56 ate the toast slowly, and stated it bothered R56 while eating and that was why R56 ate slowly. R56 wished to have no pain or discomfort when eating. Review of R56's admission MDS dated 10/19/16, revealed the facility coded to indicate R56 did not have broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose). Review of the Oral/Dental Assessment 10-14, dated 10/12/16, revealed R56 had a loose upper denture. The Apple Tree Dental assessment dated 10/21/16 read, "resident states lower gum pain. Upper denture is worn and broken, over 30 years old. A broken or loose fitting or partial denture (chipped, cracked uncleanable, or loose) Routine	F 278	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statment, the facility states that: 1. With respect to the identified MDS assessments; corrections of the prior assessments were completed on 1/12/2017 and the plan of care revised if indicated. 2. All MDS assessments for new admissions in the past month have been reviewed to assure MDS accuraccy. Corrections to prior assessments will be completed as indicated. 3. All MDSC will be re-educated by February 21, 2017 regarding MDS	

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F 278	Continued From page 2 dental referral... Needs a dental exam." Review of the care area assessment (CAA) dated 10/22/16, revealed, "[R56] has upper dentures that are loose, broken teeth r/t [related to] poor dental hygiene. Staff to asst [assist] with mouth cares BID [twice a day]. Diet as ordered. Remove top dentures at night, clean, and soak. Dental referral PRN [as needed]." Review of R56's care plan showed [R56] has a Oral/dental health problem (wears upper dentures - loose, broken teeth) r/t [related to] poor dental hygiene. Coordinate arrangements for dental care, transportation as needed/as ordered. During an interview on 1/12/17, at 3:54 p.m. the director of nursing (DON) and registered nurse consultant (RNC) verified after reviewing the medical record and the MDS, that the MDS dated 10/19/16 was coded inaccurately and needed to be modified. In addition, the DON and RNC mentioned registered nurse (RN)-C looked at it and stated section L of the MDS dated 10/19/16, was coded incorrectly, and RN-C was working on the modification. R69's admission record, revealed R69's had diagnoses of major depression, osteoporosis, and dementia with behavioral disturbance. R69's admission MDS dated 12/8/16, was coded to indicate R69 had a condition or chronic disease that may result in a life expectancy of less than 6 months. However, R69's medical record lacked physician documentation of a condition or chronic disease that may result in a life expectancy of less than 6 months. During an interview on 1/10/17, at 1:32 p.m. the	F 278	accuracy and revision of the care plan when indicated. 4. The MDS Consultant and/or designee will audit 2 resident Minimun Data Set each week for one month and then 1 resident Minimum Data Set each week for two months to assure the MDS is accurate and reflects resident conditions. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow-up studies.	

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F 278	Continued From page 3 DON confirmed the medical record lacked evidence to indicate R69 had a condition or chronic disease that may result in a life expectancy of less than 6 months. The DON said the RNC went through R69's medical record and indicated that it lacked evidence of the resident having a condition or chronic disease that may result in a life expectancy of less than 6 months, but the medical record revealed that resident had diagnosis of advanced dementia. At 1:36 p.m. the RNC verified that what the DON stated was correct. Review of the RAI [resident assessment instrument] process dated August 2015, revealed "4. Staff will complete the MDS sections assigned to them by utilizing resident assessments [user defined assessments], resident interview, staff interview, and observation of the resident while performing routine activities during the assessment reference period. B. Staff may utilize information in the medical record to assist with MDS completion that includes but is not limited to nurse's notes, physician progress notes, therapy notes, flow sheets, MAR's [medication administration record] and TAR's [treatment administration record], and laboratory reports. Information used for completion of the MDS must fall within the specified 'look back period' for each section as outlined in the RAI manual".	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review	F 279		2/21/17

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F 279	Continued From page 4 and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)-	F 279		

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F 279	Continued From page 5 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not provide an individualized hospice care plan for 1 of 1 resident (R50) reviewed for hospice care. Findings include: Record review revealed a Certificate of Terminal Illness form showing that the resident was admitted to hospice care from 10/19/16 to 1/16/17, with a primary diagnosis of chronic obstructive pulmonary disease (COPD). The record also contained a two-page [Hospice name] Hospice and Facility Coordinated Plan of Care form from the hospice provider, dated 7/22/16, that consisted of three problems: 1) Potential for knowledge deficit regarding Hospice Philosophy, services and Advanced Directives, 2) Potential for patient comfort decline related to the Hospice diagnosis of Pulmonary Disease, and 3) Accurate and current documentation in Facility Medical Record. This care plan was a generic	F 279	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficienies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident #50, the care plan was developed to include all hospice care/services provided. The resident has since discharged from the facility. 2. All residents currently receiving hospice services will have their care plans reviewed to assure hospice goals and services are incorporated into the resident's plan of care and visits	

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F 279	Continued From page 6 form with the only individualized areas being the resident's diagnosis and the frequency of visits from the hospice nurse and aide. The facility's current plan of care, dated 10/26/16, contained two problems related to hospice for R50. The first problem read, "[R50] has a terminal prognosis requiring hospice involvement/palliative care [related to] Adult [Failure To Thrive], Lung Cancer, Chronic Emphysema, COPD." The interventions for these problems were generic: assess coping strategies and respect wishes, encourage support system of family and friends, adjust provisions of ADL's (Activities of Daily Living) to compensate for changing abilities. An intervention for this problem also directed staff to see the hospice three-ring binder for the hospice providers coordinated plan of care. The second problem addressed recreational therapy for R50 and was the part of the plan of care that included specific, individualized details about this one aspect of R50's hospice care, reading, "[R50] has little interest or activity involvement [related to] disinterest and end of life care with hospice election. [R50] states that [R50] prefers to be in [resident] room and watch [television] and sleep." In an interview on 1/12/17, at 8:53 a.m. the director of nursing (DON) was asked about the generic quality of hospice plan of care for R50 and if the DON knew why the facility staff was not aware that hospice staff visited R50. The DON thought that the facility staff would need more training on these issues.	F 279	communicated to the staff via the NAR Assignment Sheet. 3. All nursing staff will be re-educated by February 21, 2017 regarding revisions to care plans when a resident is enrolled in hospice to incorporate hospice cares/services into the plan of care. 4. The Director of Nursing and/or designee will audit 1 resident care plan each week to assure care plans are accurate and reflect hospice services. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow-up studies.	
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280		2/21/17

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F 280 SS=D	Continued From page 7 PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and	F 280		

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F 280	Continued From page 8 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280		

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F 280	Continued From page 9 assessments. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to revise the care plan with interventions to reduce risk of falls for 1 of 5 residents (R71) reviewed for falls. Findings include: Review of a fall report dated 12/21/16 revealed R71 fell while trying to take off socks and shoes before going to bed. R71 sustained a hip fracture. This report included a list of interventions taken to prevent incident reoccurrence. One intervention listed was to have staff "after dinner, ask resident what time [R71] would like to go to bed and assist [R71] with getting ready for bed." Review of R71's electronic medical record revealed R71 went to the hospital after falling on 12/21/16, and returned to the facility on 12/26/16. R71's care plan lacked the intervention listed on the fall report. During interview on 1/21/17, at 10:31 a.m. registered nurse (RN)-B confirmed the interventions put in place after R71's fall. RN-B said staff were to ask R71 after dinner what time R71 would like to go to bed, so staff could be there to assist. When asked if the intervention was written in the care plan, RN-B reviewed the current care plan in the paper chart, with a print date of 9/7/16, and was unable to find the intervention. RN-B confirmed that the care plan was not updated with the intervention. RN-B confirmed that the paper care plan was more up to date than the electronic version, and said, "I will make sure to update that," before handwriting	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficienies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident #71, interventions for fall prevention were reviewed, and revised as indicated and the care plan updated. The NAR Care Plan has been updated to include appropriate fall interventions. 2. All residents who have fallen in the past 3 months will have their care plans reviewed to assure appropriate intervetnions are in place and communicated to all staff via the resident care plan and NAR Assignment Sheet. 3. All nursing staff will be re-educated by February 21, 2017 regarding revisions to care plans when a change in condition occurs. 4. The Director of Nursing and/or designee will audit 2 resident care plans each week for one month and then 1 resident care plan each week for two	

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F 280	Continued From page 10 the intervention on the care plan. Review of the facility standards guideline titled, Care Plan Completion, last revised 8/13, revealed the following requirement: "The comprehensive care plan is updated/revised as changes occur." According to the document, interventions to prevent and reduce falls should be part of a resident's care plan.	F 280	months to assure care plans are accurate and reflect fall risks and interventions. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow-up studies.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to follow the plan of care for 1 of 5 residents (R97) reviewed for falls. Findings include: On 01/12/2017, at 9:16 a.m., R97 was observed in R97's room in a wheelchair, next to the bed, with eyes closed. At 9:30 a.m., registered nurse (RN)-A, and nursing assistant (NA)-D entered R97's room and assisted R97 into the bed. When interviewed at 9:43 a.m., NA-D indicated R97 was on NA-C's group, and RN-A indicated after walking past R97's room, and seeing R97 sitting up, RN-A went to get a nursing assistant to lay R97 down.	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficienies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident #97, interventions for fall prevention were reviewed, revised as indicated and the	2/21/17

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F 282	Continued From page 11 Review of R97's care plan dated 11/29/16 indicated R97 was at a high risk for falls, and was updated on 12/27/16 with the intervention to "assist resident to bed instead of leaving [R97] in wheelchair unattended." The nursing assistant care plan dated 1/12/17 indicated "lay down after meals = do not leave unattended in room or w/c (wheelchair)." When interviewed on 1/12/17, at 9:44 a.m., NA-C indicated feeding R97 in R97's room and at 9:15 a.m., R97 was left in the wheelchair with the TV (television) on, alone in room. NA-C explained the plan was to go back in a "short while." When interviewed on 01/12/2017, at 9:53 a.m., RN-B indicated that it is the expectation that the care plan would be followed. RN-B indicated R97 should not be left alone in a wheelchair in the resident's room.	F 282	care plan updated. The NAR Care Plan has been updated to include appropriate fall interventions. 2. All residents who have fallen in the past 3 months will have their care plans reviewed to assure appropriate interventions are in place and comminicated to all staff via the resident care plan and the NAR Assignment Sheet. 3. All nursing staff will be re-educated by February 21, 2017 regarding revisions to care plans when a change in condition occurs. 4. The Director of Nursing and/or designee will audit 2 resident care plans each week for one month and then 1 resident care plan each week for two months to assure all care plans are accurate and reflect fall risks and interventions. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow-up studies.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and	F 309		2/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	01/12/2017

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F 309	Continued From page 12 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not provide an individualized hospice care plan and coordination of hospice services with the hospice provider for 1 of 1 resident (R50) reviewed for hospice care. Findings include: Record review revealed a Certificate of Terminal Illness form showing that R50 was admitted to hospice care from 10/19/16 to 1/16/17, with a primary diagnosis of chronic obstructive pulmonary disease (COPD). The record also contained a two-page [Hospice name] Hospice and Facility Coordinated Plan of Care form from the hospice provider, dated 7/22/16, that consisted of three problems: 1)	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficienies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident #50, the care plan was developed to include all hospice care/services provided. The resident has since discharged from the facility.	

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F 309	Continued From page 13 Potential for knowledge deficit regarding Hospice Philosophy, services and Advanced Directives, 2) Potential for patient comfort decline related to the Hospice diagnosis of Pulmonary Disease, and 3) Accurate and current documentation in Facility Medical Record. This care plan was a generic form with the only individualized areas being the resident's diagnosis and the frequency of visits from the hospice nurse and aide. The facility's current plan of care, dated 10/26/16, contained two problems related to hospice for R50. The first problem read, "[R50] has a terminal prognosis requiring hospice involvement/palliative care [related to] Adult [Failure To Thrive], Lung Cancer, Chronic Emphysema, COPD." The interventions for this problems were generic: assess coping strategies and respect wishes, encourage support system of family and friends, adjust provisions of ADL's (Activities of Daily Living) to compensate for changing abilities. An intervention for this problem also directed staff to see the hospice three-ring binder for the hospice providers coordinated plan of care. The second problem addressed recreational therapy for R50 and was the part of the plan of care that included specific, individualized details about this one aspect of R50's hospice care, reading, "[R50] has little interest or activity involvement [related to] disinterest and end of life care with hospice election. [R50] states that [R50] prefers to be in [resident] room and watch [television] and sleep." The record contained an "anticipated visit schedule" from the hospice provider that showed a hospice aide was scheduled to visit R50	F 309	2. All residents currently receiving hospice services will have their care plans reviewed to assure hospice goals and services are incorporated into the resident's plan of care and visits communicated to staff via the NAR Assignment Sheet. 3. All nursing staff will be re-educated by February 21, 2017 regarding revisions to care plans when a resident is enrolled in hospice to incorporate hospice cares/services into the plan of care. The contracted hospice was contacted and informed of the required documentation for maintaining communication with the facility staff. 4. The Director of Nursing and/or designee will audit 1 resident care plan each week to assure care plans are accurate and reflect hospice services. 5. The data collected will be presented at QAPI by the Director of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow-up residents.	

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F 309	Continued From page 14 Monday and Thursday 1-3 p.m., and a hospice nurse every Wednesday. The nurse's visit schedule was added to this form on 1/11/17. When interviewed on 1/11/17, at 1:51 p.m. licensed practical nurse (LPN)-A was asked by a surveyor if R50 received visits or care from the hospice provider's staff, and LPN-A did not know. LPN-A also confirmed generally working on R50's unit. During interview on 1/11/17, at 1:58 p.m. nursing assistant (NA)-A was asked the same question and confirmed often caring for R50, but not seeing hospice staff visit R50. NA-A replied with never being told that the hospice staff would provide any care for R50, so NA-A provided all of R50's care. The director of nursing (DON) was interviewed on 1/12/17 at 8:53 a.m. and asked by a surveyor about the generic quality of hospice plan of care for R50 and if the DON knew why the facility staff was not aware that hospice staff visits R50. The DON thought that facility staff must not know where to find the hospice provider's schedule and the facility staff would need more training on these issues.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision	F 323		2/21/17

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F 323	Continued From page 15 and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services to minimize the risk for falls for 2 of 5 residents (R97 and R71) reviewed for falls. Findings include: On 01/12/17, at 9:16 a.m., R97 was observed in R97's room in a wheelchair, next to the bed, with eyes closed. At 9:30 a.m., registered nurse (RN)-A, and nursing assistant (NA)-D entered R97's room and assisted R97 into the bed. When interviewed at 9:43 a.m., NA-D indicated R97 was on NA-C's group, and RN-A indicated after walking past R97's room, and seeing the resident sitting up, RN-A went to get a nursing assistant to lay R97 down. When interviewed on 1/12/17, at 9:44 a.m., NA-C	F 323	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficienies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to residents #71 and #97, interventions for fall prevention were reviewed, revised as indicated and the care plan updated to include appropriate fall interventions.	

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F 323	Continued From page 16 indicated feeding R97 in the resident's room, and at 9:15 a.m., left R97 in the wheelchair with the TV (television) on, and planned on going back in a "short while." When interviewed on 01/12/2017, at 9:53 a.m., RN-B indicated that it is the expectation that the care plan would be followed. RN-B indicated the resident should not be left alone in a wheelchair in the resident's room. Review of R97's care plan dated 11/29/16, indicated R97 was at a high risk for falls, and was updated on 12/27/16 with the intervention to "assist resident to bed instead of leaving [R97] in wheelchair unattended." The nursing assistant care plan dated 1/12/17 indicated "lay down after meals = do not leave unattended in room or w/c (wheelchair)." The Resident Incident Report dated 12/17/16, indicated R97 was observed on the floor laying next to bed. No injury was noted. The report indicated the immediate intervention implemented as "assisted to bed by staff, contact doctor about recent medication change." No change to care plan. The Resident Incident Report dated 12/27/16, indicated, R97 was found lying on left side next to the bed at 10:25 a.m. R97 had no complaints of pain and could move all extremities. The report indicated the immediate intervention implemented as "careplan [R97] to not be left alone in wheelchair/offer to lay down after meals." The Morse fall scale dated 12/27/16, after the fall, indicated R97 was at high risk for falling.	F 323	2. All residents who have fallen in the past 3 months will have their care plans reviewed to assure appropriate interventions are in place and communicated to all staff via the resident care plan and NAR Assignment Sheet. 3. All nursing staff with be re-educated by February 21, 2017 regarding revisions to care plans when a change in condition occurs. 4. The Director of Nursing and/or designee will audit 2 resident care plans each week for one month then 1 resident care plan each week for two months to assure all care plans are accurate and reflect fall risks and interventions. 5. The data collected will be presented at QAPI by the Driector of Nursing. The data will be reviewed/discussed and decision/recommendations made regarding any necessary follow-up studies.	

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F 323	Continued From page 17	F 323		

During observation on 1/9/17, at 5:37 p.m. R71 sat in a wheelchair next to the bed. The lights were off and the room was dark. R71 explained was waiting for help from staff to go to bed.

During an interview on 1/9/17, at 6:04 p.m., registered nurse (RN)-B said R71 fell on 12/21/16 while trying to take off shoes and socks whenn alone in room. R71 slipped and fell, and sustained left hip fracture.

Review of a fall report dated 12/21/16 revealed at the time of the incident R71 told the unit nurse "I was trying to take my socks and shoes off and go to bed." This report included a list of interventions taken to prevent incident reoccurrence. One intervention listed was to have staff "after dinner, ask resident what time [R71] would like to go to bed and assist [R71] with getting ready for bed."

Review of R71's electronic medical record revealed R71 went to the hospital after falling on 12/21/16, and returned to the facility on 12/26/16. R71's care plan lacked the intervention listed on the fall report.

During interview on 1/21/17, at 10:31 a.m. registered nurse (RN)-B confirmed the interventions put in place after R71's fall. RN-B said staff were to ask R71 after dinner what time R71 would like to go to bed, so staff could be there to assist. When asked if the intervention was written in the care plan, RN-B reviewed the current care plan in the paper chart, with a print date of 9/7/16, and was unable to find the intervention. RN-B confirmed that the care plan was not updated with the intervention. RN-B confirmed that the paper care plan was more up to date than the electronic version, and said, "I

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F 323	Continued From page 18 will make sure to update that," before handwriting the intervention on the care plan. RN-B was asked whether facility staff were aware of the intervention, and whether staff asked R71 after dinner about what time R71 wanted to go to bed. RN-B said because staff were told to ask R71 about bed time after dinner, RN-B had assumed this was happening. Review of the facility standards guideline titled, Care Plan Completion, last revised 8/13, revealed the following requirement: "The comprehensive care plan is updated/revised as changes occur." According to the document, interventions to prevent and reduce falls should be part of a resident's care plan. Review of a Morse Fall Scale assessment completed on 12/28/16 after returning from the hospital, revealed the facility assessed R71 to have a high risk for falling.	F 323		

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	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2017**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Bethel Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/10/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Woodlyn Heights Healthcare Center is a 2-story building with no basement. The building was built in 1973 and was determined to be of Type II(111) construction. In 2014 a single story addition was added to the East and was determined to be of Type II(111) construction. This facility was surveyed as two separate buildings because of different dates of construction. Building 1 was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19, and building 2 was surveyed in accordance with LSC Chapter 18. The builfing is fully fire sprinklered. and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The	K 000		

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K 000	Continued From page 2 facility has a capacity of 99 beds and had a census of 68 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This **STANDARD** is not met as evidenced by: Based on observation, the facility has failed to properly maintain the fire alarm system in accordance with NFPA 72, 1999 Edition. This deficient practice could affect all occupants including patients, staff and visitors. Findings include: During documentation review between 09:00 AM and 1:00 PM on 1/26/2017, it was noted during review of fire alarm documentation that Fire Alarm System was not tested within the required 365 days. This deficient practice was verified by the Maintenance Director (TG).	K 345	Woodlyn Heights will ensure the facility maintains the fire alarm system in accordance with NFPA 72 Life Safety Code Standard. 1. The facility tour on 01/26/2017 revealed that the Fire Alarm System was not tested within the required 365 days. 2. Corrective action was taken prior to the facility tour, the Fire Alarm System was tested and passed on 12/16/2016. 3. The Fire Alarm System will be tested within the required 365 days from 12/16/2016.	2/21/17

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K 345	Continued From page 3	K 345	4. Maintenance Director and/or designee is responsible for the corrective action and monitoring.	
K 712 SS=C	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Base on review of records and staff interview, it was determined that the facility failed to conducte a fire drill, for one shift in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 99 residents. Findings include: On facility tour between 9:00 AM and 1:00 PM on January 26, 2017, a review of the available fire drill reports in 2016 revealed that the facility failed to conduct a fire drill for the first shift 0630-1530 during the 4th quarter of 2016 in accordance with Section 19.7.1.2.	K 712	Woodlyn Heights will ensure the facility fire drills are conducted in accordance with NFPA 101 Life Safety Code Standard. 1. The facility tour on 01/26/2017 revealed that the first shift fire drill was not completed as required in the 4th quarter of 2016. 2. The facility Maintenance Director and/or designee will conduct the required fire drills once on each indiviual shift once every quarter of the year. Drills will be properly recorded. 3. A fire drill matrix has been created and	2/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	**2060 UPPER 55TH STREET EAST** **INVER GROVE HEIGHTS, MN 55077**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 4 This deficient practice was confirmed by the Director of Maintenance (TG).	K 712	will be utilized as a general schedule and guideline for drills. 4. Maintenance Director and/or designee is responsible for the corrective action and monitoring.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 3, 2017

Ms. Emily Jenkins, Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, Minnesota 55077

RE: Project Number F5320026

Dear Ms. Jenkins:

Please note: Health and Life Safety Code (LSC) surveys will be processed under separate enforcement cycles.

On January 26, 2017, a standard survey was completed at your facility by the Minnesota Department of Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This Life Safety Code (LSC) survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the LSC Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT of PUBLIC SAFETY CONTACT

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 7, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 26, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00829	A. BUILDING: _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 9th, 10th, 11th and 12th, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and	2 302		2/21/17

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2 302	Continued From page 2 (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide consumers written or electronic information regarding the frequency of the Alzheimer's disease or related disorders training, and the categories of employees trained. This had the potential to affect all residents in the facility. Findings include: During an interview on 1/12/17, at 3:48 p.m. the registered nurse consultant said the facility notified consumers of the dementia training by including two documents about the training in admission packets. The documents were titled, The CARES Dementia Basics & Advanced Care, and Enriching Connections. Review of The CARES Dementia Basics & Advanced Care, and Enriching Connections documents revealed a lack of information regarding the frequency of the training, and the categories of employees trained. During an interview on 1/12/17, at 4:34 p.m. the community life director (CLD) confirmed that the facility provided The CARES Dementia Basic &	2 302	Corrected	

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2 302	Continued From page 3 Advanced Care, and Enriching Connections documents to consumers as a description of the training program. The CLD was not aware of any other written or electronic notification currently given to consumers about the training. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding frequency of the staff training, and the categories of employees trained to the resident admission packet so consumers were aware of this information. Appropriate staff could be informed/educated regarding the requirement and their responsibility to ensure it is met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide an individualized hospice care plan for 1 of 1 resident (R50) reviewed for hospice care.	2 560	Corrected	2/21/17

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2 560	Continued From page 4 Findings include: Record review revealed a Certificate of Terminal Illness form showing that the resident was admitted to hospice care from 10/19/16 to 1/16/17, with a primary diagnosis of chronic obstructive pulmonary disease (COPD). The record also contained a two-page [Hospice name] Hospice and Facility Coordinated Plan of Care form from the hospice provider, dated 7/22/16, that consisted of three problems: 1) Potential for knowledge deficit regarding Hospice Philosophy, services and Advanced Directives, 2) Potential for patient comfort decline related to the Hospice diagnosis of Pulmonary Disease, and 3) Accurate and current documentation in Facility Medical Record. This care plan was a generic form with the only individualized areas being the resident's diagnosis and the frequency of visits from the hospice nurse and aide. The facility's current plan of care, dated 10/26/16, contained two problems related to hospice for R50. The first problem read, "[R50] has a terminal prognosis requiring hospice involvement/palliative care [related to] Adult [Failure To Thrive], Lung Cancer, Chronic Emphysema, COPD." The interventions for these problems were generic: assess coping strategies and respect wishes, encourage support system of family and friends, adjust provisions of ADL's (Activities of Daily Living) to compensate for changing abilities. An intervention for this problem also directed staff to see the hospice three-ring binder for the hospice providers coordinated plan of care. The second problem addressed recreational therapy for R50 and was the part of the plan of	2 560		

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2 560	Continued From page 5 care that included specific, individualized details about this one aspect of R50's hospice care, reading, "[R50] has little interest or activity involvement [related to] disinterest and end of life care with hospice election. [R50] states that [R50] prefers to be in [resident] room and watch [television] and sleep." In an interview on 1/12/17, at 8:53 a.m. the director of nursing (DON) was asked about the generic quality of hospice plan of care for R50 and if the DON knew why the facility staff was not aware that hospice staff visited R50. The DON thought that the facility staff would need more training on these issues. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed, revised as needed, staff trained and systems assessed, monitored and evaluated to assure the comprehensive plan of care is developed and lists measurable objectives and timetables to meet each residents individual needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		2/21/17

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2 565	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility failed to follow the plan of care for 1 of 5 residents (R97) reviewed for falls. Findings include: On 01/12/2017, at 9:16 a.m., R97 was observed in R97's room in a wheelchair, next to the bed, with eyes closed. At 9:30 a.m., registered nurse (RN)-A, and nursing assistant (NA)-D entered R97's room and assisted R97 into the bed. When interviewed at 9:43 a.m., NA-D indicated R97 was on NA-C's group, and RN-A indicated after walking past R97's room, and seeing R97 sitting up, RN-A went to get a nursing assistant to lay R97 down. Review of R97's care plan dated 11/29/16 indicated R97 was at a high risk for falls, and was updated on 12/27/16 with the intervention to "assist resident to bed instead of leaving [R97] in wheelchair unattended." The nursing assistant care plan dated 1/12/17 indicated "lay down after meals = do not leave unattended in room or w/c (wheelchair)." When interviewed on 1/12/17, at 9:44 a.m., NA-C indicated feeding R97 in R97's room and at 9:15 a.m., R97 was left in the wheelchair with the TV (television) on, alone in room. NA-C explained the plan was to go back in a "short while." When interviewed on 01/12/2017, at 9:53 a.m., RN-B indicated that it is the expectation that the care plan would be followed. RN-B indicated R97 should not be left alone in a wheelchair in the resident's room.	2 565	Corrected	

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2 565	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to revise the care plan with interventions to reduce risk of falls for 1 of 5 residents (R71) reviewed for falls. Findings include:	2 570	Corrected	2/21/17

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2 570	Continued From page 8 Review of a fall report dated 12/21/16 revealed R71 fell while trying to take off socks and shoes before going to bed. R71 sustained a hip fracture. This report included a list of interventions taken to prevent incident reoccurrence. One intervention listed was to have staff "after dinner, ask resident what time [R71] would like to go to bed and assist [R71] with getting ready for bed." Review of R71's electronic medical record revealed R71 went to the hospital after falling on 12/21/16, and returned to the facility on 12/26/16. R71's care plan lacked the intervention listed on the fall report. During interview on 1/21/17, at 10:31 a.m. registered nurse (RN)-B confirmed the interventions put in place after R71's fall. RN-B said staff were to ask R71 after dinner what time R71 would like to go to bed, so staff could be there to assist. When asked if the intervention was written in the care plan, RN-B reviewed the current care plan in the paper chart, with a print date of 9/7/16, and was unable to find the intervention. RN-B confirmed that the care plan was not updated with the intervention. RN-B confirmed that the paper care plan was more up to date than the electronic version, and said, "I will make sure to update that," before handwriting the intervention on the care plan. Review of the facility standards guideline titled, Care Plan Completion, last revised 8/13, revealed the following requirement: "The comprehensive care plan is updated/revised as changes occur." According to the document, interventions to prevent and reduce falls should be part of a resident's care plan.	2 570		

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(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
2 570	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide an individualized hospice care plan and coordination of hospice services	2 830	Corrected	2/21/17

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2 830	Continued From page 10	2 830		

with the hospice provider for 1 of 1 resident (R50) reviewed for hospice care and based on observation, interview, and document review, the facility failed to provide care and services to minimize the risk for falls for 2 of 5 residents (R97 and R71) reviewed for falls.

Findings include:

HOSPICE:

Record review revealed a Certificate of Terminal Illness form showing that R50 was admitted to hospice care from 10/19/16 to 1/16/17, with a primary diagnosis of chronic obstructive pulmonary disease (COPD).

The record also contained a two-page [Hospice name] Hospice and Facility Coordinated Plan of Care form from the hospice provider, dated 7/22/16, that consisted of three problems: 1) Potential for knowledge deficit regarding Hospice Philosophy, services and Advanced Directives, 2) Potential for patient comfort decline related to the Hospice diagnosis of Pulmonary Disease, and 3) Accurate and current documentation in Facility Medical Record. This care plan was a generic form with the only individualized areas being the resident's diagnosis and the frequency of visits from the hospice nurse and aide.

The facility's current plan of care, dated 10/26/16, contained two problems related to hospice for R50. The first problem read, "[R50] has a terminal prognosis requiring hospice involvement/palliative care [related to] Adult [Failure To Thrive], Lung Cancer, Chronic Emphysema, COPD." The interventions for this problems were generic: assess coping strategies and respect wishes, encourage support system of

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2 830	Continued From page 11 family and friends, adjust provisions of ADL's (Activities of Daily Living) to compensate for changing abilities. An intervention for this problem also directed staff to see the hospice three-ring binder for the hospice providers coordinated plan of care. The second problem addressed recreational therapy for R50 and was the part of the plan of care that included specific, individualized details about this one aspect of R50's hospice care, reading, "[R50] has little interest or activity involvement [related to] disinterest and end of life care with hospice election. [R50] states that [R50] prefers to be in [resident] room and watch [television] and sleep." The record contained an "anticipated visit schedule" from the hospice provider that showed a hospice aide was scheduled to visit R50 Monday and Thursday 1-3 p.m., and a hospice nurse every Wednesday. The nurse's visit schedule was added to this form on 1/11/17. When interviewed on 1/11/17, at 1:51 p.m. licensed practical nurse (LPN)-A was asked by a surveyor if R50 received visits or care from the hospice provider's staff, and LPN-A did not know. LPN-A also confirmed generally working on R50's unit. During interview on 1/11/17, at 1:58 p.m. nursing assistant (NA)-A was asked the same question and confirmed often caring for R50, but not seeing hospice staff visit R50. NA-A replied with never being told that the hospice staff would provide any care for R50, so NA-A provided all of R50's care. The director of nursing (DON) was interviewed on	2 830		

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2 830	Continued From page 12 1/12/17 at 8:53 a.m. and asked by a surveyor about the generic quality of hospice plan of care for R50 and if the DON knew why the facility staff was not aware that hospice staff visits R50. The DON thought that facility staff must not know where to find the hospice provider's schedule and the facility staff would need more training on these issues. FALLS: R97, on 01/12/17, at 9:16 a.m., was observed in R97's room in a wheelchair, next to the bed, with eyes closed. At 9:30 a.m., registered nurse (RN)-A, and nursing assistant (NA)-D entered R97's room and assisted R97 into the bed. When interviewed at 9:43 a.m., NA-D indicated R97 was on NA-C's group, and RN-A indicated after walking past R97's room, and seeing the resident sitting up, RN-A went to get a nursing assistant to lay R97 down. When interviewed on 1/12/17, at 9:44 a.m., NA-C indicated feeding R97 in the resident's room, and at 9:15 a.m., left R97 in the wheelchair with the TV (television) on, and planned on going back in a "short while." When interviewed on 01/12/2017, at 9:53 a.m., RN-B indicated that it is the expectation that the care plan would be followed. RN-B indicated the resident should not be left alone in a wheelchair in the resident's room. Review of R97's care plan dated 11/29/16, indicated R97 was at a high risk for falls, and was updated on 12/27/16 with the intervention to "assist resident to bed instead of leaving [R97] in wheelchair unattended." The nursing assistant care plan dated 1/12/17 indicated "lay down after	2 830		

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2 830	Continued From page 13 meals = do not leave unattended in room or w/c (wheelchair)." The Resident Incident Report dated 12/17/16, indicated R97 was observed on the floor laying next to bed. No injury was noted. The report indicated the immediate intervention implemented as "assisted to bed by staff, contact doctor about recent medication change." No change to care plan. The Resident Incident Report dated 12/27/16, indicated, R97 was found lying on left side next to the bed at 10:25 a.m. R97 had no complaints of pain and could move all extremities. The report indicated the immediate intervention implemented as "careplan [R97] to not be left alone in wheelchair/offer to lay down after meals." The Morse fall scale dated 12/27/16, after the fall, indicated R97 was at high risk for falling. R71, during observation on 1/9/17, at 5:37 p.m. R71 sat in a wheelchair next to the bed. The lights were off and the room was dark. R71 explained was waiting for help from staff to go to bed. During an interview on 1/9/17, at 6:04 p.m., registered nurse (RN)-B said R71 fell on 12/21/16 while trying to take off shoes and socks whenn alone in room. R71 slipped and fell, and sustained left hip fracture. Review of a fall report dated 12/21/16 revealed at the time of the incident R71 told the unit nurse "I was trying to take my socks and shoes off and go to bed." This report included a list of interventions taken to prevent incident reoccurrence. One	2 830		

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2 830	Continued From page 14 intervention listed was to have staff "after dinner, ask resident what time [R71] would like to go to bed and assist [R71] with getting ready for bed." Review of R71's electronic medical record revealed R71 went to the hospital after falling on 12/21/16, and returned to the facility on 12/26/16. R71's care plan lacked the intervention listed on the fall report. During interview on 1/21/17, at 10:31 a.m. registered nurse (RN)-B confirmed the interventions put in place after R71's fall. RN-B said staff were to ask R71 after dinner what time R71 would like to go to bed, so staff could be there to assist. When asked if the intervention was written in the care plan, RN-B reviewed the current care plan in the paper chart, with a print date of 9/7/16, and was unable to find the intervention. RN-B confirmed that the care plan was not updated with the intervention. RN-B confirmed that the paper care plan was more up to date than the electronic version, and said, "I will make sure to update that," before handwriting the intervention on the care plan. RN-B was asked whether facility staff were aware of the intervention, and whether staff asked R71 after dinner about what time R71 wanted to go to bed. RN-B said because staff were told to ask R71 about bed time after dinner, RN-B had assumed this was happening. Review of the facility standards guideline titled, Care Plan Completion, last revised 8/13, revealed the following requirement: "The comprehensive care plan is updated/revised as changes occur." According to the document, interventions to prevent and reduce falls should be part of a resident's care plan.	2 830		

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2 830	Continued From page 15 Review of a Morse Fall Scale assessment completed on 12/28/16 after returning from the hospital, revealed the facility assessed R71 to have a high risk for falling. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to hospice and falls, monitoring and care, and could provide staff education related to the care of resident related to hospice and falls. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 9th, 10th, 11th and 12th, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and	2 302		

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2 302	Continued From page 2 (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide consumers written or electronic information regarding the frequency of the Alzheimer's disease or related disorders training, and the categories of employees trained. This had the potential to affect all residents in the facility. Findings include: During an interview on 1/12/17, at 3:48 p.m. the registered nurse consultant said the facility notified consumers of the dementia training by including two documents about the training in admission packets. The documents were titled, The CARES Dementia Basics & Advanced Care, and Enriching Connections. Review of The CARES Dementia Basics & Advanced Care, and Enriching Connections documents revealed a lack of information regarding the frequency of the training, and the categories of employees trained. During an interview on 1/12/17, at 4:34 p.m. the community life director (CLD) confirmed that the facility provided The CARES Dementia Basic &	2 302		

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2 302	Continued From page 3 Advanced Care, and Enriching Connections documents to consumers as a description of the training program. The CLD was not aware of any other written or electronic notification currently given to consumers about the training. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding frequency of the staff training, and the categories of employees trained to the resident admission packet so consumers were aware of this information. Appropriate staff could be informed/educated regarding the requirement and their responsibility to ensure it is met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide an individualized hospice care plan for 1 of 1 resident (R50) reviewed for hospice care.	2 560		

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2 560	Continued From page 4 Findings include: Record review revealed a Certificate of Terminal Illness form showing that the resident was admitted to hospice care from 10/19/16 to 1/16/17, with a primary diagnosis of chronic obstructive pulmonary disease (COPD). The record also contained a two-page [Hospice name] Hospice and Facility Coordinated Plan of Care form from the hospice provider, dated 7/22/16, that consisted of three problems: 1) Potential for knowledge deficit regarding Hospice Philosophy, services and Advanced Directives, 2) Potential for patient comfort decline related to the Hospice diagnosis of Pulmonary Disease, and 3) Accurate and current documentation in Facility Medical Record. This care plan was a generic form with the only individualized areas being the resident's diagnosis and the frequency of visits from the hospice nurse and aide. The facility's current plan of care, dated 10/26/16, contained two problems related to hospice for R50. The first problem read, "[R50] has a terminal prognosis requiring hospice involvement/palliative care [related to] Adult [Failure To Thrive], Lung Cancer, Chronic Emphysema, COPD." The interventions for these problems were generic: assess coping strategies and respect wishes, encourage support system of family and friends, adjust provisions of ADL's (Activities of Daily Living) to compensate for changing abilities. An intervention for this problem also directed staff to see the hospice three-ring binder for the hospice providers coordinated plan of care. The second problem addressed recreational therapy for R50 and was the part of the plan of	2 560		

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2 560	Continued From page 5 care that included specific, individualized details about this one aspect of R50's hospice care, reading, "[R50] has little interest or activity involvement [related to] disinterest and end of life care with hospice election. [R50] states that [R50] prefers to be in [resident] room and watch [television] and sleep." In an interview on 1/12/17, at 8:53 a.m. the director of nursing (DON) was asked about the generic quality of hospice plan of care for R50 and if the DON knew why the facility staff was not aware that hospice staff visited R50. The DON thought that the facility staff would need more training on these issues. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed, revised as needed, staff trained and systems assessed, monitored and evaluated to assure the comprehensive plan of care is developed and lists measurable objectives and timetables to meet each residents individual needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		

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2 565	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility failed to follow the plan of care for 1 of 5 residents (R97) reviewed for falls. Findings include: On 01/12/2017, at 9:16 a.m., R97 was observed in R97's room in a wheelchair, next to the bed, with eyes closed. At 9:30 a.m., registered nurse (RN)-A, and nursing assistant (NA)-D entered R97's room and assisted R97 into the bed. When interviewed at 9:43 a.m., NA-D indicated R97 was on NA-C's group, and RN-A indicated after walking past R97's room, and seeing R97 sitting up, RN-A went to get a nursing assistant to lay R97 down. Review of R97's care plan dated 11/29/16 indicated R97 was at a high risk for falls, and was updated on 12/27/16 with the intervention to "assist resident to bed instead of leaving [R97] in wheelchair unattended." The nursing assistant care plan dated 1/12/17 indicated "lay down after meals = do not leave unattended in room or w/c (wheelchair)." When interviewed on 1/12/17, at 9:44 a.m., NA-C indicated feeding R97 in R97's room and at 9:15 a.m., R97 was left in the wheelchair with the TV (television) on, alone in room. NA-C explained the plan was to go back in a "short while." When interviewed on 01/12/2017, at 9:53 a.m., RN-B indicated that it is the expectation that the care plan would be followed. RN-B indicated R97 should not be left alone in a wheelchair in the resident's room.	2 565		

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	00829	A. BUILDING: _____ B. WING _____	01/12/2017

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2 565	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to revise the care plan with interventions to reduce risk of falls for 1 of 5 residents (R71) reviewed for falls. Findings include:	2 570		

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2 570	Continued From page 8 Review of a fall report dated 12/21/16 revealed R71 fell while trying to take off socks and shoes before going to bed. R71 sustained a hip fracture. This report included a list of interventions taken to prevent incident reoccurrence. One intervention listed was to have staff "after dinner, ask resident what time [R71] would like to go to bed and assist [R71] with getting ready for bed." Review of R71's electronic medical record revealed R71 went to the hospital after falling on 12/21/16, and returned to the facility on 12/26/16. R71's care plan lacked the intervention listed on the fall report. During interview on 1/21/17, at 10:31 a.m. registered nurse (RN)-B confirmed the interventions put in place after R71's fall. RN-B said staff were to ask R71 after dinner what time R71 would like to go to bed, so staff could be there to assist. When asked if the intervention was written in the care plan, RN-B reviewed the current care plan in the paper chart, with a print date of 9/7/16, and was unable to find the intervention. RN-B confirmed that the care plan was not updated with the intervention. RN-B confirmed that the paper care plan was more up to date than the electronic version, and said, "I will make sure to update that," before handwriting the intervention on the care plan. Review of the facility standards guideline titled, Care Plan Completion, last revised 8/13, revealed the following requirement: "The comprehensive care plan is updated/revised as changes occur." According to the document, interventions to prevent and reduce falls should be part of a resident's care plan.	2 570		

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2 570	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not provide an individualized hospice care plan and coordination of hospice services	2 830		

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2 830	Continued From page 10 with the hospice provider for 1 of 1 resident (R50) reviewed for hospice care and based on observation, interview, and document review, the facility failed to provide care and services to minimize the risk for falls for 2 of 5 residents (R97 and R71) reviewed for falls. Findings include: HOSPICE: Record review revealed a Certificate of Terminal Illness form showing that R50 was admitted to hospice care from 10/19/16 to 1/16/17, with a primary diagnosis of chronic obstructive pulmonary disease (COPD). The record also contained a two-page [Hospice name] Hospice and Facility Coordinated Plan of Care form from the hospice provider, dated 7/22/16, that consisted of three problems: 1) Potential for knowledge deficit regarding Hospice Philosophy, services and Advanced Directives, 2) Potential for patient comfort decline related to the Hospice diagnosis of Pulmonary Disease, and 3) Accurate and current documentation in Facility Medical Record. This care plan was a generic form with the only individualized areas being the resident's diagnosis and the frequency of visits from the hospice nurse and aide. The facility's current plan of care, dated 10/26/16, contained two problems related to hospice for R50. The first problem read, "[R50] has a terminal prognosis requiring hospice involvement/palliative care [related to] Adult [Failure To Thrive], Lung Cancer, Chronic Emphysema, COPD." The interventions for this problems were generic: assess coping strategies and respect wishes, encourage support system of	2 830		

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2 830	Continued From page 11	2 830		

family and friends, adjust provisions of ADL's (Activities of Daily Living) to compensate for changing abilities. An intervention for this problem also directed staff to see the hospice three-ring binder for the hospice providers coordinated plan of care.

The second problem addressed recreational therapy for R50 and was the part of the plan of care that included specific, individualized details about this one aspect of R50's hospice care, reading, "[R50] has little interest or activity involvement [related to] disinterest and end of life care with hospice election. [R50] states that [R50] prefers to be in [resident] room and watch [television] and sleep."

The record contained an "anticipated visit schedule" from the hospice provider that showed a hospice aide was scheduled to visit R50 Monday and Thursday 1-3 p.m., and a hospice nurse every Wednesday. The nurse's visit schedule was added to this form on 1/11/17.

When interviewed on 1/11/17, at 1:51 p.m. licensed practical nurse (LPN)-A was asked by a surveyor if R50 received visits or care from the hospice provider's staff, and LPN-A did not know. LPN-A also confirmed generally working on R50's unit.

During interview on 1/11/17, at 1:58 p.m. nursing assistant (NA)-A was asked the same question and confirmed often caring for R50, but not seeing hospice staff visit
R50. NA-A replied with never being told that the hospice staff would provide any care for R50, so NA-A provided all of R50's care.

The director of nursing (DON) was interviewed on

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2 830	Continued From page 12 1/12/17 at 8:53 a.m. and asked by a surveyor about the generic quality of hospice plan of care for R50 and if the DON knew why the facility staff was not aware that hospice staff visits R50. The DON thought that facility staff must not know where to find the hospice provider's schedule and the facility staff would need more training on these issues. FALLS: R97, on 01/12/17, at 9:16 a.m., was observed in R97's room in a wheelchair, next to the bed, with eyes closed. At 9:30 a.m., registered nurse (RN)-A, and nursing assistant (NA)-D entered R97's room and assisted R97 into the bed. When interviewed at 9:43 a.m., NA-D indicated R97 was on NA-C's group, and RN-A indicated after walking past R97's room, and seeing the resident sitting up, RN-A went to get a nursing assistant to lay R97 down. When interviewed on 1/12/17, at 9:44 a.m., NA-C indicated feeding R97 in the resident's room, and at 9:15 a.m., left R97 in the wheelchair with the TV (television) on, and planned on going back in a "short while." When interviewed on 01/12/2017, at 9:53 a.m., RN-B indicated that it is the expectation that the care plan would be followed. RN-B indicated the resident should not be left alone in a wheelchair in the resident's room. Review of R97's care plan dated 11/29/16, indicated R97 was at a high risk for falls, and was updated on 12/27/16 with the intervention to "assist resident to bed instead of leaving [R97] in wheelchair unattended." The nursing assistant care plan dated 1/12/17 indicated "lay down after	2 830		

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2 830	Continued From page 13 meals = do not leave unattended in room or w/c (wheelchair)." The Resident Incident Report dated 12/17/16, indicated R97 was observed on the floor laying next to bed. No injury was noted. The report indicated the immediate intervention implemented as "assisted to bed by staff, contact doctor about recent medication change." No change to care plan. The Resident Incident Report dated 12/27/16, indicated, R97 was found lying on left side next to the bed at 10:25 a.m. R97 had no complaints of pain and could move all extremities. The report indicated the immediate intervention implemented as "careplan [R97] to not be left alone in wheelchair/offer to lay down after meals." The Morse fall scale dated 12/27/16, after the fall, indicated R97 was at high risk for falling. R71, during observation on 1/9/17, at 5:37 p.m. R71 sat in a wheelchair next to the bed. The lights were off and the room was dark. R71 explained was waiting for help from staff to go to bed. During an interview on 1/9/17, at 6:04 p.m., registered nurse (RN)-B said R71 fell on 12/21/16 while trying to take off shoes and socks whenn alone in room. R71 slipped and fell, and sustained left hip fracture. Review of a fall report dated 12/21/16 revealed at the time of the incident R71 told the unit nurse "I was trying to take my socks and shoes off and go to bed." This report included a list of interventions taken to prevent incident reoccurrence. One	2 830		

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2 830	Continued From page 14 intervention listed was to have staff "after dinner, ask resident what time [R71] would like to go to bed and assist [R71] with getting ready for bed." Review of R71's electronic medical record revealed R71 went to the hospital after falling on 12/21/16, and returned to the facility on 12/26/16. R71's care plan lacked the intervention listed on the fall report. During interview on 1/21/17, at 10:31 a.m. registered nurse (RN)-B confirmed the interventions put in place after R71's fall. RN-B said staff were to ask R71 after dinner what time R71 would like to go to bed, so staff could be there to assist. When asked if the intervention was written in the care plan, RN-B reviewed the current care plan in the paper chart, with a print date of 9/7/16, and was unable to find the intervention. RN-B confirmed that the care plan was not updated with the intervention. RN-B confirmed that the paper care plan was more up to date than the electronic version, and said, "I will make sure to update that," before handwriting the intervention on the care plan. RN-B was asked whether facility staff were aware of the intervention, and whether staff asked R71 after dinner about what time R71 wanted to go to bed. RN-B said because staff were told to ask R71 about bed time after dinner, RN-B had assumed this was happening. Review of the facility standards guideline titled, Care Plan Completion, last revised 8/13, revealed the following requirement: "The comprehensive care plan is updated/revised as changes occur." According to the document, interventions to prevent and reduce falls should be part of a resident's care plan.	2 830		

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2 830	Continued From page 15 Review of a Morse Fall Scale assessment completed on 12/28/16 after returning from the hospital, revealed the facility assessed R71 to have a high risk for falling. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to hospice and falls, monitoring and care, and could provide staff education related to the care of resident related to hospice and falls. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		