DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL	ID: 0K40
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Facility ID: 00829
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245320 		3. NAME AND ADI (L3) WOODLYN			CENTER	4. TYPE OF ACTION: 7 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO.		(L4) 2060 UPPER	55TH STREET	EAST		3. Termination 4. CHOW
(L2) 679736900		(L5) INVER GRO	VE HEIGHTS, N	ΔN	(L6) 55077	5. Validation 6. Complaint 7. On-Site Visit 9. Other
 EFFECTIVE DATE CHANGE OF OWNERSHII (L9) 	Р	7. PROVIDER/SUF	PPLIER CATEGORY	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 03/01/2017	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:			
From (a):		X A. In Complian			And/Or Approved Waivers Of The	
To (b) :		Program Re Compliance			2. Technical Personnel 3. 24 Hour RN	 6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 99	9 (L18)	1. A	acceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room Size
	9 (L17)	B Not in Com	pliance with Program	ı	5. Life Safety Code	9. Beds/Room
			and/or Applied Waiv		* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF 99	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS (IF AI	PPLICABLE S	HOW LTC CANCELL	ATION DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APP	PROVAL Date:
Susanne Reuss, HF	E NE II		02/13/2017	(L19)	Kate JohnsTon, Pr	ogram Specialist 03/31/2017 (L20)
PAI	RT II - TO	BE COMPLETE	D BY HCFA RH	EGIONAL	OFFICE OR SINGLE STAT	E AGENCY
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C ITS ACT:	IVIL		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to Participate		1001			3. Both of the Above :	
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE 23. L'	TC AGREEMI	ENT 2	4. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)
	BEGINNING I		ENDING DATE	E	VOLUNTARY 00	
07/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement
		E SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension of				04-Other Reason for Withdrawal	07-Provider Status Change
			(L44)			00-Active
(L27) E	B. Rescind Sus	pension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
		03001				
(L2	28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	ГЕ	Posted 04/06/2017 Co.	
(L3	32)	03/09/2017		(L33)	DETERMINATION APPROV	VAL



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.

Woodlyn Heights Healthcare Center March 31, 2017 Page 2

Sincerely,

ato Comston Ł

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



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.

Woodlyn Heights Healthcare Center March 21, 2017 Page 2

Sincerely,

Sto Comston X

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



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.

Woodlyn Heights Healthcare Center March 21, 2017 Page 2

Sincerely,

Sto Comston X

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245320 _{Y1}	B. Wing	Y2	3/1/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLYN HEIGHTS HEALTHCA	RE 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).

ITE	М	DATE	ITEM	DA	те	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	F0278	Correction	ID Prefix F0279	Corr	ection ID	Prefix	F0280	Correction
Reg. #	483.20(g)-(j)	Completed	483.20((d);483.21(b)(1) Com	pleted Re		483.10(c)(2)(i-ii,iv,v) (3),483.21(b)(2)	Completed
LSC		02/21/2017	LSC	02/21	/2017 LS	SC		02/21/2017
ID Prefix	F0282	Correction	ID Prefix F0309	Corr	ection ID	Prefix	F0323	Correction
Reg. #	483.21(b)(3)(ii)	Completed	483.24, Reg. #	483.25(k)(l) Com	pleted Re	eg. #	483.25(d)(1)(2)(n)(1)-(3)	Completed
LSC		02/21/2017	LSC	02/21	/2017 LS	SC		02/21/2017
ID Prefix		Correction	ID Prefix	Corr	ection ID	Prefix		Correction
Reg. #		Completed	Reg. #	Com	pleted Re	eg. #		Completed
LSC			LSC		LS	SC		
ID Prefix		Correction	ID Prefix	Corr	ection ID	Prefix		Correction
Reg. #		Completed	Reg. #	Com	pleted Re	eg. #		Completed
LSC			LSC		LS	SC		
ID Prefix		Correction	ID Prefix	Corr	ection ID	Prefix		Correction
Reg. #		Completed	Reg. #	Com	pleted Re	eg. #		Completed
LSC					LS	SC		
REVIEWE		REVIEWED BY (INITIALS) SR/KJ	date 03/21/2017	SIGNATURE OF SURVEY		7010	рате 03	/01/2017
REVIEWE	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWL	JP TO SURVEY CO 7	OMPLETED ON		ANY UNCORRECTED DEF TED DEFICIENCIES (CMS-2				YES 🗌 NO

POST-CERTIFICATION REVISIT REPORT

			DATE OF REVISIT	
	0	Y2	3/10/2017	Y3
IDENTIFICATION NUMBER A. Building 01 - MAIN BUILDING 01		STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLYN HEIGHTS HEALTHCA	RE 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).

ITE	M	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix Reg. # LSC	NFPA 101 K0345	Correction Completed 03/10/2017	ID Prefix	01 Correction 02 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
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
REVIEWE STATE AC REVIEWE CMS RO FOLLOWI 1/26/201		REVIEWED BY (INITIALS) TL/KJ REVIEWED BY (INITIALS)		SIGNATURE OF SURVEYOR TITLE ANY UNCORRECTED DEFICIENCIES TED DEFICIENCIES (CMS-2567) SEN		DATE 3/10/2017 DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICATIO						ID: 0K40		
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY		Facility ID: 00829		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245320		3. NAME AND ADD (L3) WOODLYN			CENTER	4. TYPE OF 1. Initial	ACTION: <u>2 (</u> L8) 2. Recertification		
2.STATE VENDOR OR MEDICAID NO.		(L4) 2060 UPPER	55TH STREET I	EAST		3. Termina			
(L2) 679736900		(L5) INVER GRO	VE HEIGHTS, N	1N	(L6) 55077	5. Validatio			
 EFFECTIVE DATE CHANGE OF OWNERS (L9) 	HIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site 8. Full Sur	Visit 9. Other vey After Complaint		
6. DATE OF SURVEY 01/12/2017	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF				
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAF	R ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/	30		
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:						
From (a):		X A. In Complian	nce With		And/Or Approved Waivers (Of The Following Requir	ements:		
То (b):		Program Re Compliance			2. Technical Person 3. 24 Hour RN	—	ope of Services Limit edical Director		
12 T-4-1 T	00 (1.19)	<u>X</u> 1. A	cceptable POC		4. 7-Day RN (Rural	I SNF) 8. Pat	ient Room Size		
12. Total Facility Beds	99 (L18)	D. N. C.	1' 'd D		5. Life Safety Code	9. Bec	ds/Room		
13.Total Certified Beds	99 (L17)		pliance with Program and/or Applied Waive		* Code: A1*	(L12)			
14. LTC CERTIFIED BED BREAKDOWN			PP		15. FACILITY MEETS	()			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	a.	15)		
99	17 5141	icr	IID		1801 (e) (1) 01 1801 (j) (1).	(2	,		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARKS (IF	APPLICABLE S	HOW LTC CANCELL	ATION DATE):		I				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENO	CY APPROVAL	Date:		
Momodou Fatty, HI	FE NE II		02/13/2017	(L19)	Kate JohnsTon,	Program Spe	ecialist 03/09/2017 (L20)		
P	ART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SINGLE S	STATE AGENCY			
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH CI ITS ACT:	IVIL	2. Ownership/Co	Financial Solvency (HCFA ontrol Interest Disclosure	/		
X 1. Facility is Eligible to Participat	e				3. Both of the Al	bove :			
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE 23	. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTIO	DN:	(L30)		
OF PARTICIPATION 07/01/1986	BEGINNING	DATE	ENDING DATE	2	<u>VOLUNTARY</u> 01-Merger, Closure		NVOLUNTARY 15-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbu		6-Fail to Meet Agreement		
· · · · · · · · · · · · · · · · · · ·	ALTERNATIV	ESANCTIONS	(125)		03-Risk of Involuntary Termina	ation	OTHER		
25. LIC EXTENSION DATE. 27.	A. Suspension				04-Other Reason for Withdraw		17-Provider Status Change		
	A. Suspension	of Admissions.	(L44)				0-Active		
(L27)	B. Rescind Sus	pension Date:	()						
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	Έ	Posted 03/09/2017 Co.				
	(L32)			(L33)	DETERMINATION AP	PROVAL			



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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

Woodlyn Heights Healthcare Center February 2, 2017 Page 4

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

Woodlyn Heights Healthcare Center February 2, 2017 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Woodlyn Heights Healthcare Center February 2, 2017 Page 6

> 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,

Kato Comston

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				1 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245320	B. WING _		01	/12/2017
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODLY	N HEIGHTS HEALTH	ICARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5507	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	00		
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as bliance.				
F 278 SS=D	revisit of your facilit validate that substa regulations has bee your verification. 483.20(g)-(j) ASSE	acceptable POC an on-site y may be conducted to Intial compliance with the en attained in accordance with SSMENT RDINATION/CERTIFIED	F 27	78		2/21/17
00-0	(g) Accuracy of Ass	essments. The assessment lect the resident's status.				
	(h) Coordination A registered nurse each assessment v participation of hea					
	(i) Certification(1) A registered nurthe assessment is of	se must sign and certify that completed.				
		who completes a portion of the sign and certify the accuracy of assessment.				
	(j) Penalty for Falsit (1) Under Medicare who willfully and kn	and Medicaid, an individual				
		ial and false statement in a nt is subject to a civil money				
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 02/14/2017

		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM /	02/14/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING			01/1	2/2017
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLY	N HEIGHTS HEALTH	CARE CENTER			NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	 assessment; or (ii) Causes another and false statements ubject to a civil mod \$5,000 for each ass (2) Clinical disagreet material and false statements this REQUIREMENT by: Based on observation interview, the facility Minimum Data Set (R56 and R69) revise Findings include: R56 was observed breakfast in bed. The diet, but the toast with slowly, and stated it and that was why Resonant or dise Review of R56's ad revealed the facility have broken or loose (chipped, cracked, it Review of the Oral/ dated 10/12/16, revised the facility for the Oral/ dated 10/12/16,	than \$1,000 for each individual to certify a material t in a resident assessment is oney penalty or not more than sessment.	F 2	278	The preparation of the following plan correction for this deficiency does not constitute and should not be interpret as an admission nor an agreement by facility of the truth of the facts alleged conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exect solely because it is required by provis of State and Federal law. Without wai the foregoing statment, the facility sta 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 revise indicated. 2. All MDS assessments for new admissions in the past month have be reviewed to assure MDS accuraccy. Corrections to prior assessments will completed as indicated. 3. All MDSC will be re-educated by	t ed y the I on t of suted sions iving ates	
		incleanable, or loose) Routine			February 21, 2017 regarding MDS		

Facility ID: 00829

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TATEMENT OF DEFICIENCI ND PLAN OF CORRECTION	ICARE & MEDICAID SERVICES S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	()	E SURVEY PLETED
	245320	B. WING			
NAME OF PROVIDER OR SI		D. WING _	STREET ADDRESS, CITY, STATE, ZIP C		12/2017
	EALTHCARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55		
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
Review of th 10/22/16, re that are loos dental hygie cares BID [t top dentures referral PRN Review of F Oral/dental - loose, brok hygiene. Co care, transp During an in director of n consultant (medical rec 10/19/16 wa be modified mentioned r and stated s was coded i the modifica R69's admis diagnoses c and dement R69's admis to indicate F disease that less than 6 record lacke condition or life expectan	al Needs a dental exam." e care area assessment (CAA) dated vealed, "[R56] has upper dentures e, broken teeth r/t [related to] poor ne. Staff to asst [assist] with mouth vice a day]. Diet as ordered. Remove at night, clean, and soak. Dental [as needed]." 56's care plan showed [R56] has a nealth problem (wears upper dentures en teeth) r/t [related to] poor dental ordinate arrangements for de	s	 accuracy and revision of the when indicated. 4. The MDS Consultant and will audit 2 resident Minimum each week for one month ar resident Minimum Data Set two months to assure the M accurate and reflects reside 5. The data collected will be QAPI by the Director of Nurs will be reviewed/discussed a decision/recommendations regarding any necessary fol studies. 	/or designee n Data Set nd then 1 each week for DS is nt conditions. presented at sing. The data and made	

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		& MEDICAID SERVICES	1			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY IPLETED
		245320	B. WING _		01/	12/2017
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODL	N HEIGHTS HEALTH	ICARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 278 F 279 SS=D	evidence to indicate chronic disease that expectancy of less the RNC went throut indicated that it lack having a condition of result in a life expec- but the medical rec- diagnosis of advance RNC verified that we correct. Review of the RAI [instrument] process "4. Staff will complet to them by utilizing defined assessment interview, and obse performing routine assessment referent information in the m MDS completion th nurse's notes, phys notes, flow sheets, administration reco administration reco administration reco Information used for fall within the specifi section as outlined 483.20(d);483.21(b COMPREHENSIVE 483.20 (d) Use. A facility m assessments comp months in the resid	e medical record lacked e R69 had a condition or at may result in a life than 6 months. The DON said ugh R69's medical record and ked evidence of the resident or chronic disease that may ctancy of less than 6 months, ord revealed that resident had ced dementia. At 1:36 p.m. the that the DON stated was resident assessment s dated August 2015, revealed ete the MDS sections assigned resident assessments [user ofts], resident interview, staff ervation of the resident while activities during the nce period. B. Staff may utilize nedical record to assist with at includes but is not limited to iscian progress notes, therapy MAR's [medication rd] and TAR's [treatment rd], and laboratory reports. or completion of the MDS must fied 'look back period' for each in the RAI manual".)(1) DEVELOP	F 27			2/21/17

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/14/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245320	B. WING		01/	12/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODLY	'N HEIGHTS HEALTH	CARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	Continued From pa and revise the resic plan. 483.21	ge 4 lent's comprehensive care	F 279			
	(b) Comprehensive					
	comprehensive per each resident, cons set forth at §483.10 includes measurabl to meet a resident's and psychosocial n	t develop and implement a son-centered care plan for sistent with the resident rights r(c)(2) and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the sessment. The comprehensive cribe the following -				
	or maintain the resiphysical, mental, ar	t are to be furnished to attain dent's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and				
	under §483.24, §48 provided due to the	t would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6).				
	rehabilitative service provide as a result recommendations. findings of the PAS	services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record.				
	(iv)In consultation w resident's represen	vith the resident and the tative (s)-				

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	-	AND HUMAN SERVICES			RINTED: 02/14/201 FORM APPROVEI MB NO. 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245320	B. WING _		01/12/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST	
WOODLY	N HEIGHTS HEALTH	ICARE CENTER		INVER GROVE HEIGHTS, MN 55077	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO
F 279	desired outcomes. (B) The resident's p	goals for admission and poreference and potential for	F 27	9	
	whether the resider community was as	acilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate pose.			
	plan, as appropriate requirements set for section.	s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced			
	facility did not provi	nt review and interview, the de an individualized hospice resident (R50) reviewed for		The preparation of the following pl correction for this deficiency does r constitute and should not be interp as an admission nor an agreement facility of the truth of the facts alleg	not reted : by the
	Illness form showin admitted to hospice 1/16/17, with a prim	ealed a Certificate of Terminal og that the resident was e care from 10/19/16 to nary diagnosis of chronic ary disease (COPD).		the conclusions set forth in the stat of deficienies. The plan of correction prepared for this deficiency was ex solely because it is required by pro- of State and Federal law. Without we the foregoing statement, the facility that:	ement on ecuted visions vaiving
	name] Hospice and Care form from the 7/22/16, that consis Potential for knowle Philosophy, service Potential for patient	ntained a two-page [Hospice d Facility Coordinated Plan of hospice provider, dated sted of three problems: 1) edge deficit regarding Hospice es and Advanced Directives, 2) t comfort decline related to the		 With respect to resident #50, the plan was developed to include all h care/services provided. The reside since discharged from the facility. All residents currently receiving h services will have their care plans 	ospice nt has nospice
	Accurate and curre	of Pulmonary Disease, and 3) nt documentation in Facility his care plan was a generic		reviewed to assure hospice goals a services are incorporated into the resident's plan of care and visits	and

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		G	COM	PLETED
		245320	B. WING		01/	12/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
WOODLY	(N HEIGHTS HEALTH	ICARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55	077	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 6	F 279	9		
		ndividualized areas being the s and the frequency of visits urse and aide.		communicated to the staff via Assignment Sheet.	a the NAR	
	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			 3. All nursing staff will be re-e February 21, 2017 regarding care plans when a resident is hospice to incorporate hospic cares/services into the plan of 4. The Director of Nursing an designee will audit 1 resident each week to assure care pla accurate and reflect hospice 5. The data collected will be QAPI by the Director of Nurs will be reviewed/discussed a 	revisions to s enrolled in ce of care. ad/or care plan ans are services. presented at ing. The data nd	
	of care. The second proble therapy for R50 an care that included about this one aspored reading, "[R50] has involvement [relate care with hospice of	ice providers coordinated plan m addressed recreational d was the part of the plan of specific, individualized details ect of R50's hospice care, s little interest or activity d to] disinterest and end of life election. [R50] states that in [resident] room and watch ep."		decision/recommendations n regarding any necessary folk studies.		
	director of nursing generic quality of h and if the DON kne aware that hospice	1/12/17, at 8:53 a.m. the (DON) was asked about the ospice plan of care for R50 ew why the facility staff was not staff visited R50. The DON cility staff would need more				

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		AND HUMAN SERVICES				FORM	02/14/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245320	B. WING _			01/*	12/2017
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLY	N HEIGHTS HEALTH	CARE CENTER			060 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 SS=D		ige 7 NNING CARE-REVISE CP	F 28	30			
	(c)(2) The right to p and implementation	participate in the development of his or her person-centered ing but not limited to:					
	including the right to be included in the p request meetings a	cipate in the planning process, o identify individuals or roles to planning process, the right to nd the right to request son-centered plan of care.					
	expected goals and amount, frequency,	icipate in establishing the d outcomes of care, the type, and duration of care, and any d to the effectiveness of the					
	(iv) The right to rece included in the plan	eive the services and/or items of care.					
	.,	the care plan, including the gnificant changes to the plan					
	right to participate in	nall inform the resident of the n his or her treatment and sident in this right. The nust					
	(i) Facilitate the incl resident representa	lusion of the resident and/or ttive.					
	(ii) Include an asses strengths and need	ssment of the resident's ls.					
	(iii) Incorporate the	resident's personal and					

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		AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245320	B. WING			01/	12/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLY	YN HEIGHTS HEALTH				2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
		· · ·			DEFICIENCY)		
F 280	Cantinued From no	0	 				
F 200		-	F 2	280			
	Cultural preferences	s in developing goals of care.					
	483.21						
	(b) Comprehensive	Care Plans					
	(2) A comprehensiv	ve care plan must be-					
	(i) Developed within the comprehensive	n 7 days after completion of assessment.					
	(ii) Prepared by an i includes but is not li	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	rse with responsibility for the					
	(C) A nurse aide wit resident.	th responsibility for the					
	(D) A member of for	od and nutrition services staff.					
	the resident and the An explanation mus medical record if the and their resident re	racticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the n.					
		te staff or professionals in mined by the resident's needs the resident.					
		revised by the interdisciplinary sessment, including both the d quarterly review					

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		AND HUMAN SERVICES				FORM	02/14/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	· · ·	E SURVEY PLETED
		245320	B. WING	G		01/	12/2017
NAME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODLY	YN HEIGHTS HEALTH	CARE CENTER			2060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 9	F	280			
	assessments. This REQUIREMEN by: Based on documen facility failed to revisi interventions to red residents (R71) rev Findings include: Review of a fall rep R71 fell while trying before going to bed This report included prevent incident red listed was to have s what time [R71] wo [R71] with getting re Review of R71's ele revealed R71 went 12/21/16, and return R71's care plan lac the fall report. During interview on registered nurse (R interventions put in said staff were to as R71 would like to g there to assist. Whe was written in the c current care plan in date of 9/7/16, and intervention. RN-B was not updated wi confirmed that the p	NT is not met as evidenced Int review and interview, the se the care plan with uce risk of falls for 1 of 5 iewed for falls. ort dated 12/21/16 revealed to take off socks and shoes I. R71 sustained a hip fracture. d a list of interventions taken to occurrence. One intervention staff "after dinner, ask resident uld like to go to bed and assist eady for bed." ectronic medical record to the hospital after falling on ned to the facility on 12/26/16. ked the intervention listed on 1/21/17, at 10:31 a.m.			 The preparation of the following pl correction for this deficiency does r constitute and should not be interp as an admission nor an agreement facility of the truth of the facts alleg the conclusions set forth in the stat of deficienies. The plan of correction prepared for this deficiency was ex solely because it is required by proof State and Federal law. Without with foregoing statement, the facility that: 1. With respect to resident #71, interventions for fall prevention wer reviewed, and revised as indicated the care plan updated. The NAR C Plan has been updated to include appropriate fall interventions. 2. All residents who have fallen in t 3 months will have their care plans reviewed to assure appropriate intervetnions are in place and communicated to all staff via the recare plan and NAR Assignment Sh 3. All nursing staff will be re-educatified the care plans when a change in conditionation of the staff or the staff via the recare plans when a change in conditionation. 4. The Director of Nursing and/or designee will audit 2 resident care plan each week for the staff or the staff o	hot reted t by the led on tement on ecuted visions waiving y states re and are the past esident leet. ted by ons to ition	

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CENTE		AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>				APPROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245320	B. WING _		01/	12/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODLY	(N HEIGHTS HEALTH	CARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 282 SS=D	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 28	 months to assure care plans are and reflect fall risks and interven 5. The data collected will be pre QAPI by the Director of Nursing will be reviewed/discussed and decision/recommendations made regarding any necessary follow-studies. 	ntions. sented at . The data le	2/21/17
	by: Based on observat interview, the facility care for 1 of 5 resid Findings include: On 01/12/2017, at in R97's room in a v with eyes closed. A (RN)-A, and nursing R97's room and ass interviewed at 9:43 on NA-C's group, at walking past R97's	NT is not met as evidenced tion, document review, and y failed to follow the plan of lents (R97) reviewed for falls. 9:16 a.m., R97 was observed wheelchair, next to the bed, At 9:30 a.m., registered nurse g assistant (NA)-D entered sisted R97 into the bed. When a.m., NA-D indicated R97 was nd RN-A indicated after room, and seeing R97 sitting et a nursing assistant to lay		The preparation of the following correction for this deficiency doe constitute and should not be inte as an admission nor an agreem facility of the truth of the facts all the conclusions set forth in the so of deficienies. The plan of correct prepared for this deficiency was solely because it is required by of State and Federal law. Witho the foregoing statement, the fact that: 1. With respect to resident #97, interventions for fall prevention reviewed, revised as indicated a	es not erpreted ent by the leged on statement ction executed provisions ut waiving ility states	

Facility ID: 00829

		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED	
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F 282	Continued From pa	age 11	F 282	2			
	indicated R97 was updated on 12/27/1	are plan dated 11/29/16 at a high risk for falls, and was 16 with the intervention to		care plan updated. The NAR Ca has been updated to include app fall interventions.	propriate		
	"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			2. All residents who have fallen i 3 months will have their care pla reviewed to assure appropriate interventions are in place and comminicated to all staff via the care plan and the NAR Assignm	ns resident		
	indicated feeding I a.m., R97 was left (television) on, alor	on 1/12/17, at 9:44 a.m., NA-C R97 in R97's room and at 9:15 in the wheelchair with the TV ne in room. NA-C explained back in a "short while."		3. All nursing staff will be re-edu February 21, 2017 regarding rev care plans when a change in con occurs.	isions to		
	RN-B indicated tha care plan would be	on 01/12/2017, at 9:53 a.m., t it is the expectation that the followed. RN-B indicated R97 lone in a wheelchair in the		4. The Director of Nursing and/o designee will audit 2 resident ca each week for one month and th resident care plan each week fo months to assure all care plans accurate and reflect fall risks and interventions.	re plans en 1 r two are		
F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES	F 309	5. The data collected will be pres QAPI by the Director of Nursing. will be reviewed/discussed and decision/recommendations mad regarding any necessary follow- studies.	The data e	2/21/17	
SS=D	FOR HIGHEST WI						
	applies to all care a residents. Each re	fe undamental principle that and services provided to facility sident must receive and the e the necessary care and					

Facility ID: 00829

If continuation sheet Page 12 of 19

		& MEDICAID SERVICES	[DMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245320	B. WING _		01/	12/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODLY	YN HEIGHTS HEALTH	ICARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
 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 managemen provided to residents who require such service consistent with professional standards of pract the comprehensive person-centered care plan and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standard of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 		ent. and pain management is the sessment and plan of care. ent. asure that pain management is the who require such services, fessional standards of practice, person-centered care plan, goals and preferences. cility must ensure that ire dialysis receive such t with professional standards prehensive person-centered residents' goals and	F 30	9		
	by: Based on docume facility did not provi care plan and coord with the hospice pro- reviewed for hospic Findings include: Record review reve Illness form showin hospice care from primary diagnosis of pulmonary disease The record also con name] Hospice and Care form from the	ealed a Certificate of Terminal Ig that R50 was admitted to 10/19/16 to 1/16/17, with a of chronic obstructive		The preparation of the following p correction for this deficiency does constitute and should not be inter as an admission nor an agreemen facility of the truth of the facts alle the conclusions set forth in the sta of deficienies. The plan of correct prepared for this deficiency was e solely because it is required by pr of State and Federal law. Without the foregoing statement, the facili that: 1. With respect to resident #50, th plan was developed to include all care/services provided. The resid since discharged from the facility.	not preted at by the ged on atement ion xecuted pvisions waiving ty states he care hospice	

Facility ID: 00829

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		(X3) DATE	0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COM	PLETED
		245320	B. WING _			01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODL	N HEIGHTS HEALTH	ICARE CENTER			060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 309	Potential for knowle Philosophy, service Potential for patien Hospice diagnosis Accurate and curre Medical Record. T form with the only i resident's diagnosi from the hospice n The facility's currer contained two prob R50. The first prot terminal prognosis involvement/palliat [Failure To Thrive], Emphysema, COP problems were ger and respect wishes family and friends, (Activities of Daily I changing abilities. problem also direct three-ring binder for coordinated plan of The second proble therapy for R50 an care that included about this one aspor reading, "[R50] has involvement [relate care with hospice of [R50] prefers to be [television] and sleat The record contain	edge deficit regarding Hospice es and Advanced Directives, 2) it comfort decline related to the of Pulmonary Disease, and 3) ent documentation in Facility This care plan was a generic individualized areas being the s and the frequency of visits urse and aide. In the plan of care, dated 10/26/16, blems related to hospice for blem read, "[R50] has a requiring hospice ive care [related to] Adult Lung Cancer, Chronic D." The interventions for this heric: assess coping strategies is, encourage support system of adjust provisions of ADL's Living) to compensate for An intervention for this ted staff to see the hospice or the hospice providers f care. Im addressed recreational d was the part of the plan of specific, individualized details ect of R50's hospice care, s little interest or activity ed to] disinterest and end of life election. [R50] states that in [resident] room and watch	F 3(09	 All residents currently receiving heservices will have their care plans reviewed to assure hospice goals ar services are incorporated into the resident's plan of care and visits communicated to staff via the NAR Assignment Sheet. All nursing staff will be re-educate February 21, 2017 regarding revisio care plans when a resident is enrolle hospice to incorporate hospice cares/services into the plan of care. contracted hospice was contacted a informed of the required documenta for maintaining communication with facility staff. The Director of Nursing and/or designee will audit 1 resident care p each week to assure care plans are accurate and reflect hospice service The data collected will be present QAPI by the Director of Nursing. The will be reviewed/discussed and decision/recommendations made regarding any necessary follow-up residents. 	ed by ons to ed in The and attion the blan ess. ted at	

If continuation sheet Page 14 of 19

		AND HUMAN SERVICES			FORM): 02/14/201 / APPROVE). 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED	
		245320	B. WING _		01	/12/2017	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
WOODLY	N HEIGHTS HEALTH	ICARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55	5077		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF		(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC DATE	
F 309	Continued From pa	age 14	F 30	9			
	Monday and Thurs nurse every Wedne	day 1-3 p.m., and a hospice esday. The nurse's visit ed to this form on 1/11/17.					
		on 1/11/17, at 1:51 p.m. Jurse (LPN)-A was asked by a					
	surveyor if R50 rec	eived visits or care from the					
		staff, and LPN-A did not know. ned generally working on R50's					
	assistant (NA)-A wa and confirmed ofte seeing hospice star R50. NA-A replied	with never being told that the I provide any care for R50, so					
F 323 SS=D	1/12/17 at 8:53 a.m about the generic of for R50 and if the D was not aware that DON thought that f where to find the ho the facility staff would these issues.	sing (DON) was interviewed on a. and asked by a surveyor quality of hospice plan of care DON knew why the facility staff hospice staff visits R50. The acility staff must not know ospice provider's schedule and uld need more training on 1)-(3) FREE OF ACCIDENT VISION/DEVICES		23		2/21/17	
	(d) Accidents. The facility must er	nsure that -					
		vironment remains as free rds as is possible; and					
	(2) Each resident re	eceives adequate supervision					

Facility ID: 00829

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. (X3) DAT	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED	
		245320	B. WING _			12/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ξ		
WOODLY	N HEIGHTS HEALTH	CARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 550	77		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
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		F 32	23			
	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	s and benefits of bed rails with dent representative and obtain					
	appropriate for the This REQUIREMEN by: Based on observat review, the facility fa services to minimiz	bed's dimensions are resident's size and weight. NT is not met as evidenced tion, interview, and document ailed to provide care and e the risk for falls for 2 of 5 R71) reviewed for falls.		The preparation of the followin correction for this deficiency de constitute and should not be in as an admission nor an agreen facility of the truth of the facts	terpreted ment by the		
	R97's room in a wh eyes closed. At 9:3 (RN)-A, and nursing R97's room and assinterviewed at 9:43 on NA-C's group, a walking past R97's sitting up, RN-A we lay R97 down.	16 a.m., R97 was observed in eelchair, next to the bed, with 30 a.m., registered nurse g assistant (NA)-D entered sisted R97 into the bed. When a.m., NA-D indicated R97 was nd RN-A indicated after room, and seeing the resident nt to get a nursing assistant to on 1/12/17, at 9:44 a.m., NA-C		 the conclusions set forth in the of deficiencies. The plan of correspondence of this deficiency was solely because it is required by of State and Federal law. With the foregoing statement, the fat that: 1. With respect to residents #7 interventions for fall prevention reviewed, revised as indicated care plan updated to include a fall interventions. 	statement ection s executed provisions out waiving icility states 1 and #97, were and the		

Facility ID: 00829

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STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245320	B. WING _			01/12/2017	
NAME OF	PROVIDER OR SUPPLIER	1	1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	• • •	
WOODL	(N HEIGHTS HEALTH	ICARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 550			77	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 323	at 9:15 a.m., left R TV (television) on, a "short while." When interviewed of RN-B indicated that care plan would be resident should not in the resident's roo Review of R97's cat indicated R97 was updated on 12/27/1 "assist resident to be wheelchair unatten care plan dated 1/1 meals = do not leav (wheelchair)." The Resident Incid indicated R97 was next to bed. No inju- indicated the imme as "assisted to bed recent medication of plan. The Resident Incid indicated, R97 was to the bed at 10:25 of pain and could m report indicated the implemented as "ca- alone in wheelchair	A97 in the resident's room, and 97 in the wheelchair with the and planned on going back in on 01/12/2017, at 9:53 a.m., t it is the expectation that the followed. RN-B indicated the t be left alone in a wheelchair	F 32	23	 All residents who have fallen in 3 months will have their care plans reviewed to assure appropriate interventions are in place and communicated to all staff via the recare plan and NAR Assignment St All nursing staff with be re-educ February 21, 2017 regarding revisic care plans when a change in condoccurs. The Director of Nursing and/or designee will audit 2 resident care each week for one month then 1 recare plan each week for two month assure all care plans are accurate reflect fall risks and interventions. The data collected will be prese QAPI by the Driector of Nursing. T will be reviewed/discussed and decision/recommendations made regarding any necessary follow-up studies. 	esident neet. ated by ons to ition plans esident ns to and nted at he data	

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATI	0938-039 SURVEY PLETED
		245320	B. WING _		01/	12/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODL	YN HEIGHTS HEALTH	ICARE CENTER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 323	During observation sat in a wheelchair were off and the ro was waiting for help During an interview registered nurse (F while trying to take alone in room. R71 sustained left hip fr Review of a fall rep the time of the incid was trying to take r to bed." This report taken to prevent intervention listed v ask resident what t bed and assist [R7 Review of R71's el revealed R71 went 12/21/16, and retur R71's care plan lac the fall report. During interview or registered nurse (F interventions put in said staff were to a R71 would like to g there to assist. Wh was written in the o current care plan ir date of 9/7/16, and intervention. RN-B was not updated w confirmed that the	o on 1/9/17, at 5:37 p.m. R71 next to the bed. The lights om was dark. R71 explained p from staff to go to bed. y on 1/9/17, at 6:04 p.m., RN)-B said R71 fell on 12/21/16 off shoes and socks whenn slipped and fell, and	F 3			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OME											
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
		245320	B. WING			01/	12/2017				
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE	-					
WOODLYN HEIGHTS HEALTHCARE CENTER				2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE				
F 323	the intervention on asked whether facil intervention, and whether dinner about what t RN-B said because about bed time after this was happening Review of the facilit Care Plan Complet the following require care plan is update According to the do prevent and reduce resident's care plan Review of a Morse completed on 12/28	pdate that," before handwriting the care plan. RN-B was lity staff were aware of the hether staff asked R71 after time R71 wanted to go to bed. e staff were told to ask R71 er dinner, RN-B had assumed g. ty standards guideline titled, tion, last revised 8/13, revealed ement: "The comprehensive ed/revised as changes occur." ocument, interventions to e falls should be part of a n. Fall Scale assessment 8/16 after returning from the he facility assessed R71 to	F 3	323							

Facility ID: 00829

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		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	FA320026	FORM	02/13/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245320	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 PREFI) TAG) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	NITIAL COMMENTS		000		
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	POC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Divisio Bethel Care Center with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, r was found not in compliance ints for participation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	R THE FIRE SAFETY spections Division Suite 145		EPOC		
	r DIRECTOR'S OR PROVIL	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 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.
		E & MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	FIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245320	B. WING		01/:	26/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODLI	IN HEIGHTS HEALTH			2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
K 000	Continued From pa	age 1	K 0	00		
	By email to: Marian.Whitney@s Angela.Kappenma	state.mn.us and				
		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:				
	1. A description of to correct the defic	what has been, or will be, done iency.				
	2. The actual, or p	roposed, completion date.				
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.				
	2-story building wit was built in 1973 a Type II(111) constr addition was added	hts Healthcare Center is a th no basement. The building and was determined to be of ruction. In 2014 a single story d to the East and was of Type II(111) construction.				
	buildings because construction. Build March 1, 2003. Th accordance with L	irveyed as two separate of different dates of ling 1 was constructed prior to erefore, it was surveyed in SC Chapter 19, and building 2 ccordance with LSC Chapter				
	alarm system with and spaces open t	fire sprinklered. and has a fire full corridor smoke detection to the corridor that is monitored department notification. The				

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Facility ID: 00829

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		AND HUMAN SERVICES		FORM	: 02/13/201 APPROVE . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			e survey IPleted
		245320	B. WING	01/	26/2017
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST	
			-	NVER GROVE HEIGHTS, MN 55077	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
K 000	Continued From pa	-	K 000		
		ity of 99 beds and had a at the time of the survey.			
	NOT MET as evide				
	NFPA 101 Fire Alar Maintenance	m System - Testing and	K 345		2/21/17
	A fire alarm system accordance with an with the requirement Electric Code, and and Signaling Code	- Testing and Maintenance is tested and maintained in approved program complying nts of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily and NFPA 25			
	Based on observa properly maintain tl accordance with N	s not met as evidenced by: tion, the facility has failed to he fire alarm system in FPA 72, 1999 Edition. This ould affect all occupants staff and visitors.		Woodlyn Heights will ensure the facility maintains the fire alarm system in accordance with NFPA 72 Life Safety Code Standard.	
	Findings include: During documentat and 1:00 PM on 1/2 review of fire alarm	tion review between 09:00 AM 26/2017, it was noted during documentation that Fire not tested within the required		 The facility tour on 01/26/2017 revealed that the Fire Alarm System was not tested within the required 365 days. Corrective action was taken prior to the facility tour, the Fire Alarm System was tested and passed on 12/16/2016. 	1
		tice was verified by the tor (TG).		3. The Fire Alarm System will be tested within the required 365 days from 12/16/2016.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0K4021

Facility ID: 00829

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TATEMENT		(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY	
			8	NG 01 - MAIN BUILDING 01			
		245320	B. WING			26/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 345	Continued From pa	ige 3	K 34	45			
K 712	NFPA 101 Fire Drill	s	К 7 [.]	4. Maintenance Director an is responsible for the corre- monitoring.		2/21/17	
	signal and simulatic conditions. Fire dril times under varying on each shift. The s and is aware that d routine. Responsible conducting drills is persons who are qu Where drills are co 6:00 AM, a coded a instead of audible a 18.7.1.4 through 18 19.7.1.7	the transmission of a fire alarm on of emergency fire is are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established ility for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. 3.7.1.7, 19.7.1.4 through s not met as evidenced by:					
	Base on review of was determined that a fire drill, for one s 101 LSC (00) Section practice could affect of a fire. Improper of the safety of all 99	records and staff interview, it at the facility failed to conducte shift in accordance with NFPA on 19.7.1.2. This deficient ct how staff react in the event reaction by staff would affect		 Woodlyn Heights will ensufire drills are conducted in with NFPA 101 Life Safety 1. The facility tour on 01/2 that the first shift fire drill v completed as required in t of 2016. 	accordance Code Standard 6/2017 revealed vas not		
	January 26, 2017, a drill reports in 2016 failed to conduct a	veen 9:00 AM and 1:00 PM on a review of the available fire b revealed that the facility fire drill for the first shift he 4th quarter of 2016 in ection 19.7.1.2.		 2. The facility Maintenance designee will conduct the drills once on each indiviu every quarter of the year. properly recorded. 3. A fire drill matrix has be 	required fire al shift once Drills will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00829

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		AND HUMAN SERVICES			I	FORM A	02/13/201 APPROVEI 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE	SURVEY PLETED
		245320	B. WING	÷		01/2	6/2017
	PROVIDER OR SUPPLIER	ICARE CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 712	Continued From pa This deficient pract Director of Mainten	tice was confirmed by the	K	712	will be utilized as a general schedule guideline for drills. 4. Maintenance Director and/or desig is responsible for the corrective action monitoring.	gnee	
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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:

<u>Please note</u>: 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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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

Woodlyn Heights Healthcare Center February 3, 2017 Page 4

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.

Woodlyn Heights Healthcare Center February 3, 2017 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
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Electronically Signed

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If continuation sheet 1 of 16

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	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading le date your orders will be electronically submitting to the nent of Health.					
	surveyors of this D above provider and orders are issued. electronic plan of c	0th, 11th and 12th, 2017, epartment's staff, visited the d the following correction Please indicate in your orrection that you have lers, and identify the date when ted.	n				
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			2/21/17	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related segregated or gene care staff	lity serves persons with disorders, whether in a eral unit, the facility's direct ors must be trained in dementia	a				
	related disorders; (2) assistance with	ed training include: of Alzheimer's disease and activities of daily living; g with challenging behaviors;					

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2 302	 (4) communication (c) The facility shall written or electronic training program, the trained, the frequer topics covered. (d) The facility shall this section. This MN Requirem by: Based on interview facility failed to prove electronic information the Alzheimer's disc training, and the cat This had the potent facility. Findings include: During an interview registered nurse con notified consumers including two documents admission packets. The CARES Deme and Enriching Communications of the CAR Advanced Care, and documents revealer regarding the frequent categories of employ During an interview During an interview Review of The CAR	skills. provide to consumers in comma description of the ne categories of employees acy of training, and the basic document compliance with ent is not met as evidenced and document review, the vide consumers written or on regarding the frequency of ease or related disorders tegories of employees trained. ial to affect all residents in the sultant said the facility of the dementia training by ments about the training in The documents were titled, ntia Basics & Advanced Care, nections. RES Dementia Basics & d Enriching Connections d a lack of information ency of the training, and the byees trained.	2 302	Corrected		
	facility provided The epartment of Health	ctor (CLD) confirmed that the e CARES Dementia Basic &				
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2 302	Continued From pa	ge 3	2 302			
	Advanced Care, an documents to cons training program. T other written or elec given to consumers SUGGESTED MET The DON or design regarding frequenc categories of emplo admission packet s this information. Ap informed/educated their responsibility t	d Enriching Connections umers as a description of the he CLD was not aware of any ctronic notification currently about the training. THOD OF CORRECTION: the could add information y of the staff training, and the oyees trained to the resident o consumers were aware of propriate staff could be regarding the requirement and				
2 560	Plan of Care; Conters Subp. 2. Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con assessment. The con required by Minnes subdivision 14, para This MN Requirement by: Based on document facility did not provi	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560	Corrected		2/21/17
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2 560	Continued From pa	age 4	2 560			
	Findings include:					
	Illness form showin admitted to hospice 1/16/17, with a prin	ealed a Certificate of Terminal ng that the resident was e care from 10/19/16 to nary diagnosis of chronic nary 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.					
	contained two prob R50. The first prot terminal prognosis involvement/palliat [Failure To Thrive], Emphysema, COP problems were ger and respect wishes family and friends, (Activities of Daily) changing abilities. also directed staff	nt plan of care, dated 10/26/16 plems related to hospice for plem read, "[R50] has a requiring hospice ive care [related to] Adult Lung Cancer, Chronic D." The interventions for these heric: assess coping strategies s, encourage support system of adjust provisions of ADL's Living) to compensate for An intervention for this problem to see the hospice three-ring nice providers coordinated plan	f			
	or care.		II IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			

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2 560	about this one aspereading, "[R50] has involvement [related care with hospice e [R50] prefers to be [television] and slee In an interview on 1 director of nursing of generic quality of he and if the DON kne aware that hospice thought that the fact training on these is SUGGESTED MET director of nursing of policy and procedur needed, staff trainer monitored and eval comprehensive pla lists measurable of meet each resident TIME PERIOD FOR (21) days. MN Rule 4658.0409 Plan of Care; Use Subp. 3. Use. A co	specific, individualized details act of R50's hospice care, little interest or activity d to] disinterest and end of life election. [R50] states that in [resident] room and watch ep." /12/17, at 8:53 a.m. the (DON) was asked about the ospice plan of care for R50 w why the facility staff was not staff visited R50. The DON sility staff would need more sues. THOD OF CORRECTION: The or designee could assure the res are reviewed, revised as ed and systems assessed, uated to assure the n of care is developed and ojectives and timetables to is individual needs. R CORRECTION: Twenty-one 5 Subp. 3 Comprehensive omprehensive plan of care I personnel involved in the				2/21/17
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2 565	Continued From pa	ge 6	2 565			
	by: Based on observati interview, the facilit	ent is not met as evidenced on, document review, and y failed to follow the plan of lents (R97) reviewed for falls.		Corrected		
	Findings include:					
	in R97's room in a with eyes closed. A (RN)-A, and nursing R97's room and assinterviewed at 9:43 on NA-C's group, a walking past R97's	9:16 a.m., R97 was observed wheelchair, next to the bed, At 9:30 a.m., registered nurse g assistant (NA)-D entered sisted R97 into the bed. When a.m., NA-D indicated R97 was nd RN-A indicated after room, and seeing R97 sitting et a nursing assistant to lay				
	indicated R97 was a updated on 12/27/1 "assist resident to b wheelchair unattend care plan dated 1/1 meals = do not leav (wheelchair)." When interviewed of indicated feeding F a.m., R97 was left i	re plan dated 11/29/16 at a high risk for falls, and was 6 with the intervention to bed instead of leaving [R97] in ded." The nursing assistant 2/17 indicated "lay down after re unattended in room or w/c on 1/12/17, at 9:44 a.m., NA-C R97 in R97's room and at 9:15 n the wheelchair with the TV is in room. NA C available				
Ainpacette	the plan was to go l When interviewed o RN-B indicated that care plan would be	te in room. NA-C explained back in a "short while." on 01/12/2017, at 9:53 a.m., t it is the expectation that the followed. RN-B indicated R97 lone in a wheelchair in the				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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2 565	Continued From pa	age 7	2 565				
	director of nursing review and revise p to ensuring the care resident is followed designee could dev and develop a mon	THOD OF CORRECTION: The (DON) or designee could policies and procedures related e plan for each individual I. The director of nursing or velop a system to educate staff itoring system to ensure staff as directed by the written plan	I				
2 570	(21) days. MN Rule 4658.040	R CORRECTION: Twenty-one 5 Subp. 4 Comprehensive	2 570			2/21/17	
	care must be review interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	. A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal a representative at least a seven days of the revision of resident assessment required					
	by: Based on documer facility failed to revi	ent is not met as evidenced at review and interview, the se the care plan with luce risk of falls for 1 of 5 riewed for falls.		Corrected			
	Findings include:						

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If continuation sheet 8 of 16

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2 570	Continued From pa	ge 8	2 570			
	R71 fell while trying before going to bed This report included prevent incident red listed was to have s what time [R71] wo [R71] with getting re Review of R71's ele revealed R71 went 12/21/16, and retur R71's care plan lac the fall report. During interview on registered nurse (R interventions put in said staff were to a R71 would like to g there to assist. Why was written in the c current care plan in date of 9/7/16, and intervention. RN-B was not updated wi confirmed that the p to date than the ele will make sure to up the intervention on Review of the facilit Care Plan Complet the following require care plan is update	ectronic medical record to the hospital after falling on ned to the facility on 12/26/16. ked the intervention listed on 1/21/17, at 10:31 a.m. N)-B confirmed the place after R71's fall. RN-B sk R71 after dinner what time o to bed, so staff could be en asked if the intervention are plan, RN-B reviewed the the paper chart, with a print was unable to find the confirmed that the care plan th the intervention. RN-B paper care plan was more up ctronic version, and said, "I odate that," before handwriting the care plan. ty standards guideline titled, ion, last revised 8/13, revealed ement: "The comprehensive d/revised as changes occur."				
Minnesota D	epartment of Health		ř.	1		

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IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		12/2011	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 570	Continued From pa	age 9	2 570				
	director of nursing develop and impler related to care plar designee, could pro staff related to the revisions. The qual	THOD OF CORRECTION: The (DON) or designee, could nent policies and procedures a revisions. The DON or povide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to					
0.000	(21) days.	R CORRECTION: Twenty-one				0/04/47	
2 830	Proper Nursing Ca Subpart 1. Care in receive nursing car custodial care, and individual needs ar the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on of preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident	1			2/21/17	
	by: Based on documer facility did not provi	ent is not met as evidenced at review and interview, the de an individualized hospice dination of hospice services		Corrected			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00829	B. WING		01/	01/12/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
NOODL	IN HEIGHTS HEALTH		PER 55TH STE ROVE HEIGH				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 10	2 830		·		
	reviewed for hospic observation, intervi facility failed to pro	ovider for 1 of 1 resident (R50) ce care and based on iew, and document review, the vide care and services to or falls for 2 of 5 residents (R97 I for falls.					
	Findings include:						
	HOSPICE:						
	Illness form showir hospice care from	ealed a Certificate of Terminal ng that R50 was admitted to 10/19/16 to 1/16/17, with a of chronic obstructive e (COPD).					
	name] Hospice and Care form from the 7/22/16, that consis Potential for knowle Philosophy, service Potential for patien Hospice diagnosis Accurate and curre Medical Record. T form with the only i	ntained a two-page [Hospice d Facility Coordinated Plan of e hospice provider, dated sted of three problems: 1) edge deficit regarding Hospice es and Advanced Directives, 2) t comfort decline related to the of Pulmonary Disease, and 3) ent documentation in Facility 'his care plan was a generic ndividualized areas being the s and the frequency of visits urse and aide.					
	contained two prob R50. The first prot terminal prognosis involvement/palliati [Failure To Thrive], Emphysema, COP problems were ger	nt plan of care, dated 10/26/16, plems related to hospice for plem read, "[R50] has a requiring hospice ive care [related to] Adult Lung Cancer, Chronic D." The interventions for this heric: assess coping strategies s, encourage support system o					

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00829	B. WING		01 /1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
WOODLY	YN HEIGHTS HEALTH	CARE CENTER		TREET EAST HTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	(Activities of Daily L changing abilities. problem also direct three-ring binder fo coordinated plan of The second problem	n addressed recreational				
	therapy for R50 and care that included s about this one aspe- reading, "[R50] has involvement [relate- care with hospice e	d was the part of the plan of specific, individualized details ect of R50's hospice care, little interest or activity d to] disinterest and end of life lection. [R50] states that in [resident] room and watch				
	schedule" from the a hospice aide was Monday and Thurse nurse every Wedne	ed an "anticipated visit hospice provider that showed scheduled to visit R50 day 1-3 p.m., and a hospice esday. The nurse's visit d to this form on 1/11/17.				
	licensed practical n surveyor if R50 rec hospice provider's	on 1/11/17, at 1:51 p.m. urse (LPN)-A was asked by a eived visits or care from the staff, and LPN-A did not know. ed generally working on R50's				
	assistant (NA)-A wa and confirmed ofter seeing hospice stat R50. NA-A replied	with never being told that the provide any care for R50, so				
		sing (DON) was interviewed on				
Minnesota D STATE FOR	epartment of Health M		6899	0K4011	If continuatio	on sheet 12 of 16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00829	B. WING		01/	12/2017
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		12/2017
		2060 LIP	PER 55TH STF			
VOODLI	IN HEIGHTS HEALTH	ICARE CENTER INVER G	ROVE HEIGHT	rs, mn 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pa	age 12	2 830			
	about the generic of for R50 and if the I was not aware that DON thought that f where to find the h	n. and asked by a surveyor quality of hospice plan of care DON knew why the facility staff hospice staff visits R50. The facility staff must not know ospice provider's schedule and uld need more training on				
	FALLS:					
	R97's room in a wh eyes closed. At 9:3 (RN)-A, and nursin R97's room and as interviewed at 9:43 on NA-C's group, a walking past R97's	at 9:16 a.m., was observed in neelchair, next to the bed, with 30 a.m., registered nurse g assistant (NA)-D entered sisted R97 into the bed. When a.m., NA-D indicated R97 was and RN-A indicated after room, and seeing the resident ent to get a nursing assistant to	5			
	indicated feeding F at 9:15 a.m., left R	on 1/12/17, at 9:44 a.m., NA-C R97 in the resident's room, and 97 in the wheelchair with the and planned on going back in				
	RN-B indicated tha care plan would be	on 01/12/2017, at 9:53 a.m., at it is the expectation that the followed. RN-B indicated the t be left alone in a wheelchair om.				
	indicated R97 was updated on 12/27/ ⁻ "assist resident to I wheelchair unatten	are plan dated 11/29/16, at a high risk for falls, and was 16 with the intervention to bed instead of leaving [R97] in ided." The nursing assistant 12/17 indicated "lay down after				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
		00829	B. WING	B. WING		12/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
VOODLY	(N HEIGHTS HEALTH	ICARE CENTER	PER 55TH STE ROVE HEIGH ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 13	2 830			
	meals = do not lea (wheelchair)."	ve unattended in room or w/c				
	indicated R97 was next to bed. No injuindicated the imme as "assisted to bed	lent Report dated 12/17/16, observed on the floor laying ury was noted. The report ediate intervention implemented by staff, contact doctor about change." No change to care				
	indicated, R97 was to the bed at 10:25 of pain and could n report indicated the implemented as "c	lent Report dated 12/27/16, s found lying on left side next a.m. R97 had no complaints nove all extremities. The e immediate intervention areplan [R97] to not be left r/offer to lay down after meals.	"			
		le dated 12/27/16, after the fall at high risk for falling.	,			
	R71 sat in a wheel lights were off and	vation on 1/9/17, at 5:37 p.m. chair next to the bed. The the room was dark. R71 ting for help from staff to go to				
	registered nurse (F while trying to take	v on 1/9/17, at 6:04 p.m., RN)-B said R71 fell on 12/21/16 off shoes and socks whenn slipped and fell, and racture.	6			
	the time of the incid was trying to take r to bed." This report	port dated 12/21/16 revealed at dent R71 told the unit nurse "I my socks and shoes off and go t included a list of interventions cident reoccurrence. One)			

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		01/12/2017	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
OODL	(N HEIGHTS HEALTH	ICARE CENTER	PER 55TH STR ROVE HEIGHT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 14	2 830			
	ask resident what t	vas to have staff "after dinner, ime [R71] would like to go to 1] with getting ready for bed."				
	revealed R71 went 12/21/16, and retur	ectronic medical record to the hospital after falling on rned to the facility on 12/26/16. sked the intervention listed on				
	registered nurse (F interventions put in said staff were to a R71 would like to g there to assist. Wh was written in the c current care plan in date of 9/7/16, and intervention. RN-B was not updated w confirmed that the to date than the ele will make sure to u the intervention on asked whether faci intervention, and w dinner about what the RN-B said because	A 1/21/17, at 10:31 a.m. RN)-B confirmed the place after R71's fall. RN-B sk R71 after dinner what time to to bed, so staff could be en asked if the intervention care plan, RN-B reviewed the the paper chart, with a print was unable to find the confirmed that the care plan ith the intervention. RN-B paper care plan was more up ectronic version, and said, "I pdate that," before handwriting the care plan. RN-B was lity staff were aware of the hether staff asked R71 after time R71 wanted to go to bed. e staff were told to ask R71 er dinner, RN-B had assumed g.				
	Care Plan Complet the following requir care plan is update According to the do	ty standards guideline titled, tion, last revised 8/13, revealed ement: "The comprehensive d/revised as changes occur." ocument, interventions to a falls should be part of a n.				

Minnesc	ta Department of He	alth			-	-
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00829	B. WING		01/1	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WOODLY	YN HEIGHTS HEALTH			IREET EAST HTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa Review of a Morse completed on 12/28 hospital, revealed t have a high risk for SUGGESTED MET director of nursing of revise policies and and falls, monitorin staff education rela related to hospice a nursing or designed ensure appropriate	age 15 Fall Scale assessment B/16 after returning from the he facility assessed R71 to falling. THOD OF CORRECTION: The or designee, could review and procedures related to hospice g and care, and could provide ted to the care of resident and falls. The director of e could develop an audit tool to	2 830			
Minnosoto D	epartment of Health					
wiininesola D						

SIMULATION OF DEFICIENCY (n) IP BRUNCERSUPPLIENCL (p2) MUTHEL CONSTRUCTION A. BULLING (p2) MUTHEL CONSTRUCTION CONSTRUCTION (p2) MUTHEL CONSTRUCTION A. BULLING (p2) MUTHEL CONSTRUCTION CONSTRUCTION (p2) MUTHEL CONSTRUCTION CONST	Minnesot	a Department of Health	1				
MALE OF PROVIDER OR SUPPLIE Codes Contraction 2000 UPPER SITH STREET ADDRESS, CITY, STATE. 2P CODE 2000 UPPER SITH STREET EAST 2000 UPPER SITH STREET EAST INVER GROVE HEIGHTS, MAN 55077 7ms SUMMARY STATEMENT OF DEPICIENCIES Inver GROVE HEIGHTS, MAN 55077 7ms SUMMARY STATEMENT OF DEPICIENCIES Inver GROVE HEIGHTS, MAN 55077 2.000 Initial Comments 2.000 ****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A: 10, this concertion 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 shall be considered lack of compliance with all inspection, was considered lack of compliance with a schedule of fines promulgated below. Yur may request a hearing on any assessments that may result from on-compliance. NTAL COMMENTS: You may request a hearing on any assessments that may result for non-compliance. that my result for the aviolable at the learns with cereipt of a notice of assessement of a fine except of a notice of assessement or a may explain the electronic receipt of State licensinge orders are				`			
Description OPAID TWG SUMMARY STATEMENT OF DEFICIENCY (EACH CODERCY MUST BE PRECIDEND BY FULL). PROVIDER'S FULN OF CORRECTION (EACH CODERCY TWG NESD EDITITIVING INFORMANCIA) PROVIDER'S FULN OF CORRECTION CODERS (EACH CODERCY TWG NESD EDITITIVING INFORMANCIA) PREFIX TAG 2 000 Initial Comments 2 000 DEFIDIATIVICY INFORMANCIAN CORRECTION ORDER Initial Comments 2 000 Initial Comments 2 000 In accordance with Minnesota Statule, 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 lines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires several items, failure to comply with any of the items growing the violation has been corrected requires several items, failure to comply with any of the items growing that a single out that was violated during the initial inspection was corrected. Initial Comments in the action re-inspection with any item of multi-part rule will requirements of the rule provided at the tag number and full from one-compliance upon re-inspection with any item of multi-part rule will require the assessment of a fine even if the item that was violated during the initial inspection was corrected. Initial Comments that may result from non-compliance with these orders provided that a writtem requests in made to the Department within 15 days of receipt of a natice of assessment for fine-coeptip of a natice of assessment for non-compliance.			00829	B. WING		01/1	2/2017
WOODUNT HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55071 (M) ID PHETRX ID REGULATION ON LSCIENTIFICATION REGULATION ON LSCIENTIFICATION REGULATION REGULATION ON LSCIENTIFICATION REGULATION	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
INVER OROVE HEIGHTS, MI 5077 OPALID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (LOADIDEFICIENCY MAST BE PRECIDED BY FULL (PAGE ACTION SHOULD BE CARDED CONCERNT MAST BE PRECIDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CARDED CONCERNT MAST BE PRECIDED BY FULL (PAGE ACTION SHOULD BE CROSS REFERENCE) TO THE APPROPRIATE DEFICIENCY) CONCERNT CONCERNT DEFICIENCY) 2 000 Initial Comments 2 000 DEFICIENCY) DEFICIENCY) 3 000 Initial Comments 2 000 DEFICIENCY) DEFICIENCY) 3 000 Initial Comments 2 000 DEFICIENCY) DEFICIENCY) 4 000 Initial Comments 2 000 DEFICIENCY) DEFICIENCY) 3 000 Initial Comments 2 000 DEFICIENCY) DEFICIENCY) 4 000 Initial Comments 2 000 DEFICIENCY) DEFICIENCY) 1 04A 10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found and the deficiency or deficiencies cited therein are not corrected, aften for each violation has been corrected requires compliance with all requirements of the rule provided the tag number and MN Rule number indicated Delow. When a rule contains several items, failure to comply with any (tem of multipart rule will respection with any item of multipart rule will resparule in thany result from non-compliance with these orders provi			2060 UPP	ER 55TH STRE	ET EAST		
Preprint TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR US IS IDENTIFYING INFORMATION) Preprint TAG CLACH COMPRETE ACTION SHOLD DBE CROSS-REFERENCED to 114 APPROPRIATE COMPRETE DEFICIENCY 2 000 Initial Comments 2 000 2 000 Initial Comments 2 000 INITIAL CORVORUME VIAL LOENSING CORRECTION ORDER In accordance with Minnesota Statule, 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 provided tat the tag number and MN Rule number indicated below. When a rule contains several items, failure to corrected. Determination of whether a violation has been corrected. For 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 of the rule will result in the assessment for non-compliance. INITIAL COMMENTS: 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 writtin 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to pari- tion have agreed bate licensing orders are written as the licensing orders are orders consistent with the Minnesota Department of the leath informational Bulletin 14-01, available at intp://www.health.state.mus/dix/if/op/rofinfor/i	WOODLI	N HEIGHTS HEALTHCAR	INVER GR	OVE HEIGHTS	, MN 55077		
Image: Contract of the section of t	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	DBE	COMPLETE
NH LICENSING CORRECTION ORDER In accordance with Minnesola 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 reussional 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 licensing orders consistent with	2 000	Initial Comments		2 000			
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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. 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.mu.us/divs/fpc/profinfo/inf		NH LICENSING C	ORRECTION ORDER				
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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/inf obul.htm The State licensing orders are		result in the assessm that was violated duri	ent of a fine even if the item				
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/inf obul.htm The State licensing orders are		that may result from r orders provided that a the Department withir	non-compliance with these a written request is made to n 15 days of receipt of a				
Minnesota Department of Health	Minnesota Do	You have agreed to p receipt of State licens the Minnesota Depart Informational Bulletin http://www.health.stat obul.htm The State I delineated on the atta	articipate in the electronic sure orders consistent with ment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf icensing orders are				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00829	B. WING			/12/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	1 0	12/2017
NOODLYN	N HEIGHTS HEALTHCAF	RECENTER	PER 55TH STREET			
			ROVE HEIGHTS, M	PROVIDER'S PLAN		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From page	e 1	2 000			
	you electronically. All is necessary for State enter the word "corre text. You must then in State licensure proce completion date, the corrected prior to elec Minnesota Departme On January 9th, 10th surveyors of this Dep above provider and th orders are issued. Pl electronic plan of corr	n, 11th and 12th, 2017, artment's staff, visited the ne following correction lease indicate in your rection that you have s, and identify the date when				
2 302	or related disorder tra ALZHEIMER'S DISEA DISORDER TRAININ MN St. Statute 144.6 (a) If a nursing facility Alzheimer's disease or related dis segregated or general care staff and their supervisors care. (b) Areas of required	ASE OR RELATED IG: 503 v serves persons with corders, whether in a al unit, the facility's direct must be trained in dementia training include: Alzheimer's disease and	2 302			

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00829	B. WING		01	01/12/2017	
AME OF PF	ROVIDER OR SUPPLIER		I DDRESS, CITY, STATE		01	112/2011	
	N HEIGHTS HEALTHCAF	2060 UP	PER 55TH STREET	EAST			
	HEIGHTS HEALTHCAP	INVER G	ROVE HEIGHTS, N	IN 55077			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 302	Continued From page	e 2	2 302				
	written or electronic f training program, the trained, the frequency topics covered.	kills. Irovide to consumers in orm a description of the categories of employees y of training, and the basic locument compliance with					
	by: Based on interview a facility failed to provid electronic information the Alzheimer's disea training, and the cate	It is not met as evidenced nd document review, the de consumers written or n regarding the frequency of use or related disorders gories of employees trained. I to affect all residents in the					
	Findings include:						
	registered nurse cons notified consumers of including two docume admission packets. T	on 1/12/17, at 3:48 p.m. the sultant said the facility f the dementia training by ents about the training in the documents were titled, ia Basics & Advanced Care, ctions.					
	Advanced Care, and documents revealed	ncy of the training, and the					
	community life directed	on 1/12/17, at 4:34 p.m. the or (CLD) confirmed that the CARES Dementia Basic &					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	00829	DDRESS, CITY, STATE,		01	/12/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 302	Continued From page	e 3	2 302				
	documents to consum training program. The other written or electr given to consumers a SUGGESTED METH The DON or designed regarding frequency of categories of employe admission packet so this information. Appr informed/educated re their responsibility to	OD OF CORRECTION: e could add information of the staff training, and the ees trained to the resident consumers were aware of opriate staff could be garding the requirement and					
2 560	Plan of Care; Contents Subp. 2. Contents of comprehensive plan of objectives and timeta long- and short-term of and mental and psych identified in the comp assessment. The com must include the indiv required by Minnesot subdivision 14, parag This MN Requirement by: Based on document of facility did not provide	plan of care. The of care must list measurable bles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident mprehensive plan of care vidual abuse prevention plan a Statutes, section 626.557,	2 560				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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	N HEIGHTS HEALTHCAF	2060 UP	PER 55TH STREET	EAST		
	HEIGHTS HEALTHCAP	INVER G	ROVE HEIGHTS, N	IN 55077		
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2 560	Continued From page	e 4	2 560			
	Findings include:					
	Illness form showing admitted to hospice of	are from 10/19/16 to ry diagnosis of chronic				
	name] Hospice and F Care form from the he 7/22/16, that consister Potential for knowled Philosophy, services Potential for patient of Hospice diagnosis of Accurate and current Medical Record. This form with the only ind	ained a two-page [Hospice Facility Coordinated Plan of ospice provider, dated ed of three problems: 1) ge deficit regarding Hospice and Advanced Directives, 2) comfort decline related to the Pulmonary Disease, and 3) documentation in Facility s care plan was a generic lividualized areas being the and the frequency of visits se 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.					
		addressed recreational was the part of the plan of				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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2 560	Continued From page	e 5	2 560				
	about this one aspect reading, "[R50] has lin involvement [related care with hospice ele	to] disinterest and end of life ction. [R50] states that [resident] room and watch					
	director of nursing (D generic quality of hos and if the DON knew aware that hospice st	2/17, at 8:53 a.m. the ON) was asked about the pice plan of care for R50 why the facility staff was not caff visited R50. The DON ty staff would need more es.					
	director of nursing or policy and procedure needed, staff trained monitored and evalua comprehensive plan lists measurable obje meet each residents	of care is developed and ctives and timetables to individual needs.					
	(21) days.	CORRECTION: Twenty-one					
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565				
	-	nprehensive plan of care ersonnel involved in the					

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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	Continued From page	e 6	2 565			
	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:					
	in R97's room in a wh with eyes closed. At (RN)-A, and nursing a R97's room and assis interviewed at 9:43 a on NA-C's group, and walking past R97's ro	16 a.m., R97 was observed neelchair, next to the bed, 9:30 a.m., registered nurse assistant (NA)-D entered sted R97 into the bed. When .m., NA-D indicated R97 was d RN-A indicated after bom, and seeing R97 sitting a nursing assistant to lay				
	updated on 12/27/16 "assist resident to be wheelchair unattende care plan dated 1/12/	plan dated 11/29/16 a high risk for falls, and was with the intervention to d instead of leaving [R97] in ed." The nursing assistant 17 indicated "lay down after unattended in room or w/c				
	indicated feeding R9 a.m., R97 was left in	1/12/17, at 9:44 a.m., NA-C 7 in R97's room and at 9:15 the wheelchair with the TV in room. NA-C explained ack in a "short while."				
	RN-B indicated that it care plan would be for	01/12/2017, at 9:53 a.m., t is the expectation that the ollowed. RN-B indicated R97 ne in a wheelchair in the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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2 565	Continued From page	e 7	2 565				
	director of nursing (D review and revise pol to ensuring the care p resident is followed. designee could devel and develop a monito are providing care as of care.	OD OF CORRECTION: The ON) or designee could icies and procedures related blan for each individual The director of nursing or op a system to educate staff oring system to ensure staff directed by the written plan					
2 570		Subp. 4 Comprehensive	2 570				
	care must be reviewed interdisciplinary team physician, a registered for the resident, and of disciplines as determ and, to the extent pra- participation of the re- guardian or chosen re- quarterly and within s	A comprehensive plan of ed and revised by an that includes the attending ed nurse with responsibility other appropriate staff in ined by the resident's needs, acticable, with the sident, the resident's legal epresentative at least even days of the revision of esident assessment required					
	by: Based on document r facility failed to revise	ce risk of falls for 1 of 5					
	Findings include:						

STATEMEN	a Department of Healt T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:			E SURVEY PLETED
		00829	B. WING		01	/12/2017
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2 570	Continued From page	e 8	2 570			
	R71 fell while trying to before going to bed. I This report included a prevent incident reoc listed was to have sta what time [R71] woul [R71] with getting rea Review of R71's elec revealed R71 went to 12/21/16, and returne R71's care plan lacke the fall report. During interview on 1 registered nurse (RN interventions put in p said staff were to ask R71 would like to go there to assist. When was written in the car current care plan in th date of 9/7/16, and w intervention. RN-B c was not updated with confirmed that the pa to date than the elect will make sure to upd the intervention on th Review of the facility Care Plan Completion the following requirer care plan is updated/ According to the doct	tronic medical record the hospital after falling on ed to the facility on 12/26/16. ed the intervention listed on /21/17, at 10:31 a.m.)-B confirmed the lace after R71's fall. RN-B R71 after dinner what time to bed, so staff could be asked if the intervention re plan, RN-B reviewed the he paper chart, with a print ras unable to find the onfirmed that the care plan the intervention. RN-B per care plan was more up ronic version, and said, "I late that," before handwriting				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00829	B. WING			01/12/2017	
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2 570	Continued From page	9 9	2 570				
	director of nursing (D develop and impleme related to care plan re designee, could provi staff related to the tim	ide training for all nursing neliness of care plan r assessment and assurance					
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one					
2 830	Proper Nursing Care; Subpart 1. Care in generative nursing care is custodial care, and suindividual needs and the comprehensive replan of care as descri- 4658.0405. A nursing of bed as much as power the subpart of th	eneral. A resident must and treatment, personal and upervision based on preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out ossible unless there is a e attending physician that the in bed or the resident	2 830				
	by: Based on document i facility did not provide	t is not met as evidenced review and interview, the e an individualized hospice nation of hospice services					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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2 830	Continued From pag	e 10	2 830				
	reviewed for hospice observation, interview facility failed to provi	w, and document review, the de care and services to falls for 2 of 5 residents (R97					
	Findings include:						
	HOSPICE:						
	name] Hospice and I Care form from the h 7/22/16, that consiste Potential for knowled Philosophy, services Potential for patient of Hospice diagnosis of Accurate and current Medical Record. This form with the only ind	ained a two-page [Hospice Facility Coordinated Plan of tospice provider, dated ed of three problems: 1) dge deficit regarding Hospice and Advanced Directives, 2) comfort decline related to the f Pulmonary Disease, and 3) t documentation in Facility is care plan was a generic dividualized areas being the and the frequency of visits se and aide.					
	contained two proble R50. The first proble terminal prognosis re involvement/palliative [Failure To Thrive], L Emphysema, COPD	plan of care, dated 10/26/16, ems related to hospice for em read, "[R50] has a equiring hospice e care [related to] Adult ung Cancer, Chronic ." The interventions for this ric: assess coping strategies					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		01/12/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 11	2 830			
	(Activities of Daily Liv changing abilities. Ar	l staff to see the hospice he hospice providers				
	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."					
	a hospice aide was so Monday and Thursda nurse every Wedneso	ospice provider that showed cheduled to visit R50 y 1-3 p.m., and a hospice				
	surveyor if R50 receiv hospice provider's sta	1/11/17, at 1:51 p.m. se (LPN)-A was asked by a ved visits or care from the aff, and LPN-A did not know. d generally working on R50's				
	assistant (NA)-A was and confirmed often of seeing hospice staff v R50. NA-A replied wit	h never being told that the rovide any care for R50, so				
	The director of nursin	a (DON) was interviewed on				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 12	2 830			
	about the generic qua for R50 and if the DC was not aware that he DON thought that fac where to find the hos	and asked by a surveyor ality of hospice plan of care N knew why the facility staff ospice staff visits R50. The illity staff must not know pice provider's schedule and I need more training on				
	FALLS:					
	R97's room in a whee eyes closed. At 9:30 (RN)-A, and nursing a R97's room and assis interviewed at 9:43 a on NA-C's group, and walking past R97's ro	9:16 a.m., was observed in elchair, next to the bed, with a.m., registered nurse assistant (NA)-D entered sted R97 into the bed. When .m., NA-D indicated R97 was d RN-A indicated after bom, and seeing the resident to get a nursing assistant to				
	indicated feeding R9 at 9:15 a.m., left R97	1/12/17, at 9:44 a.m., NA-C 7 in the resident's room, and in the wheelchair with the id planned on going back in				
	RN-B indicated that it care plan would be for	01/12/2017, at 9:53 a.m., t is the expectation that the ollowed. RN-B indicated the e left alone in a wheelchair n.				
	indicated R97 was at updated on 12/27/16 "assist resident to be wheelchair unattende	e plan dated 11/29/16, a high risk for falls, and was with the intervention to d instead of leaving [R97] in ed." The nursing assistant '17 indicated "lay down after				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		01	/12/2017
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 01	
	N HEIGHTS HEALTHCAF	2060 UP	PER 55TH STREET	EAST		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 13	2 830			
	meals = do not leave (wheelchair)."	unattended in room or w/c				
	indicated R97 was ob next to bed. No injury indicated the immedia as "assisted to bed b	at Report dated 12/17/16, oserved on the floor laying was noted. The report ate intervention implemented y staff, contact doctor about ange." No change to care				
	indicated, R97 was for to the bed at 10:25 a. of pain and could mo report indicated the in implemented as "care	t Report dated 12/27/16, bund lying on left side next .m. R97 had no complaints ve all extremities. The mmediate intervention eplan [R97] to not be left .ffer to lay down after meals."				
	The Morse fall scale indicated R97 was at	dated 12/27/16, after the fall, high risk for falling.				
	R71 sat in a wheelch lights were off and the	ion on 1/9/17, at 5:37 p.m. air next to the bed. The e room was dark. R71 g for help from staff to go to				
	registered nurse (RN					
	the time of the incide was trying to take my to bed." This report in	t dated 12/21/16 revealed at nt R71 told the unit nurse "I socks and shoes off and go ncluded a list of interventions lent reoccurrence. One				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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2 830	Continued From page	e 14	2 830			
	ask resident what tim	s to have staff "after dinner, le [R71] would like to go to 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 Care Plan Completio the following requirer care plan is updated/ According to the doc	standards guideline titled, n, last revised 8/13, revealed nent: "The comprehensive revised as changes occur." ument, interventions to alls should be part of a				

Minnesot	a Department of Health	1				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		00829	B. WING		01/1	2/2017
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2 830	Continued From page	e 15	2 830			
	hospital, revealed the	6 after returning from the facility assessed R71 to				
	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.					
Minnocoto Do	partment of Health					