

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered November 17, 2015

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

Subject: Woodlyn Heights Healthcare Center - IDR

Provider # 245320 Project # S5320025

Dear Ms. Donahue:

This is in response to your e-mail request of August 28, 2015, in regard to your request of change from an independent informal dispute resolution (IIDR) to an informal dispute resolution (IDR) for the federal deficiency at tag F310 issued pursuant to the survey event 1RUJ11, completed on July 2, 2015.

The information presented with your letter as well as in a face to face meeting with facility staff and MDH staff on September 24, 2015, the CMS 2567 dated July 2, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F310 (G) §483.25(a)(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to --

- (i) Bathe, dress, and groom;
- (ii) Transfer and ambulate;
- (iii) Toilet;
- (iv) Eat; and
- (v) Use speech, language, or other functional communication systems.

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Summary of the facility's reason for IDR of this tag.

The facility alleges there is insufficient evidence to support a deficient practice at F310 as no harm occurred to R42. The deficient practice should be removed. The facility alleges all appropriate care and services were provided to R42 to improve and/or maintain a high quality of care and quality of life. R42 was admitted following a fall resulting in a fractured humerus. R42 had significant pain management issues related to the fracture as physicians were unable to repair the fracture surgically. Due to ongoing pain management issues, facility staff secured an orthopedic surgeon to repair the fracture. The surgery was successful in repair of the fracture and improving pain management, however, it exacerbated her congestive heart failure. Due to the significant issues with edema, R42 had a significant leg wound occur due to the inability of her skin to stretch far enough with the edema. R42 had weight bearing restrictions on the fractured arm as well as the leg following the rupture of her skin. The facility alleges that due to the numerous complications resulting from a fall at home prior to admission to the facility, the facility did everything possible to improve and maintain R42's ability to ambulate.

Summary of facts.

R42 is a 102 year old woman admitted to the facility on 2/6/15, following a hospital stay for a fall at home resulting in a fractured humerus. The hospital determined the fracture could not be surgically repaired. R42 struggled with significant pain management issues due to the fractured humerus. The facility found an orthopedic surgeon to repair the fracture and R42 was admitted for surgery on 3/12/15. R42 returned to the facility 3/15/15. R42 began therapy on 3/16/15. Following surgery, R42 experienced an exacerbation of her congestive heart failure (CHF) including significant edema, respiratory issues and lab abnormalities. R42 had regular physician intervention with regular adjustments to her medical plan. R42 developed an open area to her buttock during this time. R42 plateaued in her therapy due to limited weight bearing on the right upper extremity. As a result, on 4/10/15, R42 was discharged from physical therapy (PT). R42 did not meet goals due to the multiple complications from the humerus fracture. PT provided education to nursing staff on transfers and limited ambulation status. On 4/21/15, R42 sustained a 19 cm"Y" shaped laceration to her left lower extremity when she bumped her shin on the wheelchair footrest. This laceration was complicated due to her extensive lower extremity edema. The laceration was closed in the emergency room with 22 sutures. R42 was discharged from the emergency room with limitations on activity.

R42 ambulated 300 feet or more while in an assisted living prior to the fractured humerus. R42 had multiple complications following the fracture. There is little evidence in the medical record identifying R42's mobility status and implementation of her mobility program. There is little evidence in the medical record concerning R42's level of participation in the ambulation program and any of her choices made related to utilizing the mobility program. There was no evidence in the record concerning resident education related to the risks and benefits of refusing to implement the recommended mobility program.

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Summary of findings

This is a valid deficiency, however, the severity will be reduced. As a result of the scope and severity change, the deficient practice will now be placed under a different requirement. The following requirement is not met:

F311 §483.25(a)(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Christine Campbell, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 218-302-6151 Fax: 218-723-2359

cc: Office of Ombudsman for Long-Term Care Pam Kerssen, Assistant Program Manager Licensing and Certification File Susanne Reuss, Metro Team A Unit Supervisor

Wdlyn Hts IDR 1015

PRINTED: 12/08/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X4) ID SUMMARY STATEMEN	IT OF DEFICIENCIES BE PRECEDED BY FULL		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	07/02/2015
WOODLYN HEIGHTS HEALTHCARE	IT OF DEFICIENCIES BE PRECEDED BY FULL	ID PREFIX	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077 PROVIDER'S PLAN OF CORRECTION	, (X5)
WOODLYN HEIGHTS HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		PREFIX		(X5)
PRÉFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	ſ		CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 000 INITIAL COMMENTS	restion (POC) will conve	F 000	0	
The facility's plan of corr as your allegation of com Department's acceptance enrolled in ePOC, your s at the bottom of the first form. Your electronic sul be used as verification of	npliance upon the e. Because you are ignature is not required page of the CMS-2567 bmission of the POC will			
on-site revisit of your fac	otable electronic POC, an cility may be conducted to compliance with the ained in accordance with			
A complaint investigation investigate complaint #H #H5320042. The complaint substantiated.	15320040 and			
11/16/15 Revised CMS-2 Informal Dispute Resolu F 166 483.10(f)(2) RIGHT TO I SS=D RESOLVE GRIEVANCE	ition. PROMPT EFFORTS TO	F 16	66	8/11/15
A resident has the right t facility to resolve grievar have, including those wit of other residents.	to prompt efforts by the nces the resident may th respect to the behavior			
This REQUIREMENT is by: Based on interview and facility failed to actively rigrievances expressed for R77) regarding call light	I document review, the resolve personal or 2 of 2 residents (R9, twait times.		The preparation of the following pleasurection for this deficiency does constitute and should not be interpas an admission nor an agreemen facility of the truth of the facts alleg	not reted by the

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.

07/24/2015

Electronically Signed

PRINTED: 12/08/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIE			20	REET ADDRESS, CITY, STATE, ZIP CODE 160 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
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F 166	Findings include: The facility failed call light wait time. On 6/29/15, at 5:: (F)-B, reported stights within a reareported they had for help, and state don't come to but disposable brief the answering call light had waited in soil believed part of the not communication went on breaks a walkie talk syster lights. F-B report times, and on varextended call light at 9:08 a.m., F-B concerns about conferences, had and other staff at reported at one phalf for R9 to get them and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working." F-E brought up about response was near the same and told the added "they tell thappens, but not claim they have a not working."	to resolve a grievance regarding es, expressed by R9's family. 21 p.m., a family member of R9, aff were not responding to call isonable period of time. F-B d observed R9 wait over an hour ed "some aides don't care and iton calls." F-B added, R9 wore a pecause staff were not hits in a reasonable time and R9 led briefs. F-B reported she he problem may have been staffing with each other when they and staff may not have worn the mused to alert them of call led visiting R9 daily, at various rious shifts and had observed at times during visits. On 7/2/15, reported she had expressed call light wait times at care as spoken with the administrator pout call light concerns. F-B point, after waiting an hour and a assistance she "went off on that was not acceptable." F-B as to tell them when this hing ever changes" and "they a system, but I said clearly it is 8 reported these concerns were the 2-3 months ago and a facility	F1	66	conclusions set forth in the statemed eficiencies. The plan of correction prepared for this deficiency was exposely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#9 and R#77, patterns of call light response time assessed to determine care times, medication schedule, and activity preferences for reducing the need and wait for assistance. b) All staff will receive re-edcuation responding to call lights in a timely manner and turning off the call lighentering the room to meet individu needs. c) All staff will be re-educated on the process for following up with concentrom resident/family council meeting. d) The facility's interdisciplinary tea (IDT) will audit via resident intervie observations and/or call logs. Any light identified as excessive will be investigated. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed IDT for 3 months. f) DNS/Designee is responsible for completion.	n decuted evisions waiving y states s were to call a on at when al he erns ngs.	

Facility ID: 00829

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F 166	distributing more p call light alerts. Ho this measure had a there was no monifacility was unable monitoring. A review of call light revealed R9's call minutes on the even afternoon and even afternoon of 6/16 a mornings of 6/17, R9's most recent [MDS] dated 5/5/1 assistance to mee extensive assistant transfer, locomotic and personal hygic further revealed R impaired, and was and bowel. The facility failed to call light wait time. On 7/1/15, at 3:15 several minutes for repositioning a when his room was spoken with the addirector of nursing 7/2/15, at 10:05 a recently waited as recently waited as several waited as recently waited as recently waited as several minuted as recently waited as recently waited as several minuted as recently waited as recently waited as several minuted as recently waited as recently waited as recently waited as several minuted as recently waited	ants and were working on portable walkies to alert staff of wever, there was no indication resolved the grievance, as itoring of the measure, as the to provide documentation of that times, for June 11 - 24, 2015 light times exceeded thirty ening of 6/11/15; on the moon of 6/13/15; on the ming of 6/15/15; on the ming of 6/15/15; and on the 6/18 and 6/24/15. quarterly Minimum Data Set 5, revealed R9 required staff of basic needs including: the properties of the properties of the staff of the properties of the properties of the staff of the properties of the propert		166			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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F 166	the bed. R77 reported chronic issue with issue. Review of a feedby revealed R77 had call light wait time over a weekend. It distributing portate further monitoring A review of the carevealed R77 wai assistance on the of 6/21,6/22, 6/26 mornings of 6/22 A review of R77's revealed R77 was extensive assistate toilet use, person dependent on state of 6/2/15, at 9:02 the facility was not response times a desk. The facility response issues The facility had in from the previous concerns to their conclusion.	orted call light concerns were a not enough done to resolve the not enough done to resolve the not enough done to resolve the pack form, dated 5/11/15, expressed concerns regarding is being longer than acceptable. The facility noted they were ble walkie talkies to staff. No it or follow up was documented. It light log dated 6/21 to 6/27/15, ited over half an hour for following dates: the mornings and 6/27; and twice on the and 6/23/15. In annual MDS, dated 5/15/15 is cognitively intact and required ince for bed mobility, dressing, all hygiene, and was totally fif for transfers. If a.m. the administrator reported it regularly checking call light is she could not print it out at her had worked on call light wait times is week after surveyor brought the attention, but could not reach a		166			
	[DON] and admir regular review of issue had been d new walkie talkie	00 a.m. the director of nursing histrator reported there was no call light wait times, but the liscussed at staff meetings and s had been ordered. The DON or reported the facility should					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	2/2015
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F 166		9	F ·	166			
F 225 SS=D	have closely monit 483.13(c)(1)(ii)-(iii) INVESTIGATE/RE ALLEGATIONS/IN	PORT	F2	225			8/11/15
	been found guilty of mistreating resider had a finding enter registry concerning of residents or mistand report any known court of law against indicate unfitness.	ot employ individuals who have of abusing, neglecting, or abusing, neglecting, or ats by a court of law; or have red into the State nurse aide grabuse, neglect, mistreatment appropriation of their property; owledge it has of actions by a stran employee, which would for service as a nurse aide or to the State nurse aide registry ities.					
	involving mistreatr including injuries of misappropriation of immediately to the to other officials in through established	nsure that all alleged violations nent, neglect, or abuse, of unknown source and of resident property are reported administrator of the facility and accordance with State law ad procedures (including to the certification agency).					
	violations are thore	ave evidence that all alleged oughly investigated, and must tential abuse while the progress.					
	to the administrator representative and with State law (incordiffication agencincident, and if the	nvestigations must be reported or or his designated d to other officials in accordance luding to the State survey and ey) within 5 working days of the alleged violation is verified etive action must be taken.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIER /N HEIGHTS HEALTH	CARE CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 160 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
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F 225	Continued From pa	age 5	F2	225			
	by: Based on docume facility failed to conthorough investigat unknown origin, and details of the injury agency (SA) for 1 of for allegations of all Findings include: A facility incident reat 11:00 a.m. R43 unknown origin ide from w/c (wheel chrequired ED (emer Documentation inchad reported to the clearly identified the wound. The follow State Agency on 4 specified): "Nursin skin tear on the low Resident is unable occurred. Resident (emergency room) Internal investigation on 4/27/15 (no time had submitted to the investigative finding tear on the outer as [Nursing assistant]	nt review and interview, the applete an accurate and a failed to report accurate to the designated State of 3 residents (R43), reviewed buse/neglect or mistreatment. Seport indicated that on 4/21/15 had sustained an injury of antified as: "skin tear transfer air) to bed. Significant gash gency department) transfer." State agency, they had not be severity of the resident's air ing had been reported to the designated that although the facility of assistant reported finding a power left leg of the resident. To identify how the injury the was sent into the ER for evaluation and treatment. The of day specified), the facility the State Agency their ges: "Resident obtained a skin ispect of her left lower leg. In (NA)-C] and [NA-D] were ent with transfer to bed from			The preparation of the following pleorrection for this deficiency does a constitute and should not be interpas an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemediciencies. The plan of correction prepared for this deficiency was expolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#43, internal investigation revealed laceration like caused by the mechanism of the fron the wheelchair. b) Facility will complete and report accurate and thorough investigation agencies) within 5 working days of incident. If alleged violation is verial appropriate corrective action will be c) Staff will receive re-education or completing accurate and thorough investigations of injuries of unknown origin. d) ED/DNS will review each incide ensure an accurate and thorough investigation is completed. This	reted to the led on ent of necuted visions waiving y states ons in ng to the fied e taken.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245320	B. WING _		07/	02/2015
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN		
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F 225	complication with Resident denies tear. Resident hat the day. Therapy with therapy sess and unable to give tear was acquire to be evaluated, day with sutures internal investigaresident may have mechanism on the skin tear and wheight of injury. I investigation no substantiated." Although the facunknown origin a agency, review of documentation of described the injlower leg lacerat (centimeter) yis lateral leg that is evident. Unsure laceration, no falwheelchair. The layer suture clos placed, stitch typprolene. The lacunder a lot of ter length. The lace the skin was ver amount of tensic approximate the information from	page 6 air. Nursing assistants deny any transfer from wheelchair to bed. knowing how she obtained skin at worked with therapy earlier in staff denies any complications sion. Resident remains confused re any insight as to how the skin d. Resident was sent into the ER and returned to the facility same closing the skin tear. After tion, it appears as though the re caught her leg on the release re leg of her wheelchair, as the release align with John completion of internal abuse or neglect was a skin tear to the State of the emergency room lated 4/21/15, identified and ury of unknown origin as; "left ions. Pt (patient) has a 10-11 cm aped laceration to left lower gaping and has fat globals [sic] of what happen [sic] that caused ls, possibility a piece on the wound was closed using one ure: skin layer: 22 sutures be; simple interrupted, suture: 3-0 reation was Y- shaped, deep, rision, and measured 19 cm total ration was difficult to repair since by thin and there was a large on. Every effort was made to wound edges." The discharge the ER identified the treated 9 cm complex leg laceration.	F 22	information will be docume facility's quality assurance reviewed by IDT for 3 mone) The ED/Designee is rescompletion	meeting and ths.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 225	Data Set (MDS) da cognitively intact w assistance with act wassistance with act During an interview 7/1/15, at 8:00 a.m that occurred to R4 staff did not inform investigation as to expressed seeing a blood and fat on the transported by para room. F-A stated, "on the floor." Furth complained when the greally itches, where the greally itches, where the great was then huge "blow out" ac F-A, the emergence speculated that the in the wheel chair a pinching was relieved administrator acknowledge.	of R43's quarterly Minimum ted 5/8/15, identified R43 as ith dependence on staff for ivities of daily living (ADL's). With family member (F)-A on ., F-A discussed an incident 3 and expressed concern that F-A of the outcome of the how the incident occurred. F-A a large 7 inch plate size area of e floor before R43 was amedics to the emergency It looked like a pile of afterbirth ermore, F-A explained R43 he two aides stood her up, 'my nat is the matter with it?' The pulled up and revealed the cording to F-A. According to y room physician had a calf may have been pinched and when the pressure of the red, the skin just "blew apart". on 7/2/15 at 8:25 a.m., the owledged having been verbally ident on 4/21/15, although	F 2	225	DEFICIENCY)		
	stated he had not seemed of nursing's (DON) employment. The finding the report, it assistant director con 6/1/15. He verifularifying document conducted since as former DON had not seemed to the state of the state	seen the incident report until iscovered in the former director office after she'd left their administrator stated that upon thad been signed by the of nursing (ADON) and himselfied there had been no further tation or investigation acknowledged that the ot followed through with the e had been no statements from					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING		- (a) The	07/0)2/2015
	PROVIDER OR SUPPLIE			2	TREET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
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F 225	Continued From	page 8	F2	225			
	witness statemen no education and recurrence of the The facility's curre Vulnerable Adult included under se Source/Unexplain classified as an inboth the following Federal: a. The sobserved by any injury could not bb. The injury is su of the injury or thinjury is located in vuylnerable to traobserved at one incidence of injury State: If a reporter	ent Policy and Procedure titled, Abuse/Neglect Prevention, ection #9; "Injuries of Unknown ned Injuries. An injury should be njury of unkown source" when g conditions are met: ource of the injury was not person or the source of the e explained by the resident: and spicious because of the extent e location of the injury (e.g., the n an area not generally uma) or the number of injuries particular point in time or the ies over time. er has reason to believe that the has sustained an injury which is					
	Submitting the R Reporting proced alleged abuse/ne observed, a man make an initial re securing the resi of the situation, t report to the Adm Nursing. 2. Upon suspected abuse be interviewed, r the direct superv assigned to non-	r included information for eport, listed under Internal dures; "1. During the shift that the eglect or unexplained injury is first dated reporter will immediately eport to their Supervisor, after dent's safety. Following a review he Supervisor will immediately ninistrator and the Director of a report to a Supervisor of the e, the employee in question will e-assigned duties, placed under ision of a licensed nurse, resident related tasks or ling investigation. This is for the					

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	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	Director of Nursing immediately instituted the reported allegorated directed staff to control interviewing the form of Resident interview Resident health of Medication review 483.13(c) DEVEL ABUSE/NEGLEC The facility must of policies and process mistreatment, negorated allegorated in the resident of Nursing Resident interview and process an	esident 3. The Supervisor, g or Administrator will ute an internal investigation of ation or incident". The policy onsider investigating and ollowing: Interviews of staff, ws, Environmental review, tatus, Behavior review,	F 226			8/11/15
	by: Based on docum facility failed to im investigation relat origin for 1 of 3 re allegations of abu Findings include: The facility's curre Vulnerable Adult / included under se Source/Unexplair classified as an ir both the following Federal: a. The s observed by any	ent review and interview, the uplement their policies for ed to an injury of unknown esidents (R43), reviewed for ise/neglect or mistreatment. ent Policy and Procedure titled, Abuse/Neglect Prevention, ection #9; "Injuries of Unknown ned Injuries. An injury should be njury of unkown source" when a conditions are met: ource of the injury was not person or the source of the e explained by the resident: and		The preparation of the following placorrection for this deficiency does not constitute and should not be interprated as an admission nor an agreement facility of the truth of the facts allegor conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exposely because it is required by proving State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#43, internal investigation revealed laceration like caused by the mechanism of the form the wheelchair.	not reted by the ed on ent of n ecuted visions waiving r states	

Facility ID: 00829

Event ID:1RUJ11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY
		245320	B. WING		-	07/0	2/2015
	PROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 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 LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	b. The injury is suss of the injury or the injury or the injury or the injury is located in vuylnerable to trau observed at one princidence of injuries State: If a reporter vulnerable adult han treasonably exp. The policy further Submitting the Rel Reporting proceduralleged abuse/neg observed, a mand make an initial repsecuring the reside of the situation, the report to the Admin Nursing. 2. Upon resuspected abuse, be interviewed, rethe direct supervisus assigned to non-resuspended pending protection of the redirect of Nursing immediately instituted the reported allegated directed staff to conterviewing the form Resident interview. Resident health standard medication review.	piciouys because of the extent location of the injury (e.g., the an area not generally ma) or the number of injuries articular point in time or the es over time. has reason to believe that the as sustained an injury which is blained." included information for port, listed under Internal lives; "1. During the shift that the elect or unexplained injury is first ated reporter will immediately nort to their Supervisor, after ent's safety. Following a review to Supervisor will immediately instrator and the Director of eport to a Supervisor of the the employee in question will eassigned duties, placed under sion of a licensed nurse, esident related tasks or any investigation. This is for the esident 3. The Supervisor, gor Administrator will the an internal investigation of ation or incident". The policy onsider investigating and allowing: Interviews of staff, as, Environmental review, atus, Behavior review,		226	b) Facility will complete and report accurate and thorough investigation accordance with State law (including the State survey and certification agencies) within 5 working days of incident. If alleged violation is veri appropriate corrective action will be c) Staff will receive re-education or completing accurate and thorough investigations of injuries of unknown origin. d) ED/DNS will review each incide ensure an accurate and thorough investigation is completed. This information will be documented in facility's quality assurance meeting reviewed by IDT for 3 months. e) The ED/Designee is responsible completion	ng to the fied e taken. n th th the g and	
		had sustained an injury of entified as: "skin tear transfer					

PRINTED: 12/08/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '			COMPLETED	
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIER	ICARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	from w/c (wheel chrequired ED (emergency for the accurately described wound. The follow State Agency on 4/2 specified): "Nursing skin tear on the low Resident is unable occurred. Resident (emergency room) Internal investigation of the follow state Agency on the low Resident is unable occurred. Resident (emergency room) Internal investigation occurred investigation for the outer a [Nursing assistant] assisting the resident wheelchat complication with the Resident denies keep tear. Resident denies keep tear was acquired to be evaluated, and unable to give tear was acquired to be evaluated, and ay with sutures content investigation on the skin tear and wheel height of injury. Up	air) to bed. Significant gash gency department) transfer." icated that although the facility state agency, they had not ed the severity of the resident's ing had been reported to the 121/15 (no time of day grassistant reported finding a ver left leg of the resident. To identify how the injury the was sent into the ER for evaluation and treatment.		226			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST		(X3) DATE SURVEY COMPLETED		
		245320	B. WING			07/	02/2015	
	PROVIDER OR SUPPLIER			2060 UPP	DDRESS, CITY, STATE, ZIP CODE PER 55TH STREET EAST GROVE HEIGHTS, MN 55077	TREET EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	· '	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 226	Although the facili unknown origin as agency, review of documentation da described the inju significant; "left low has a 10-11 cm (of to left lower laterary globals [sic] evided that caused lacera on the wheelchair one layer suture of placed, stitch type prolene. The lacera under a lot of tensilength. The lacera the skin was very amount of tension approximate the winformation from a diagnosis as a 19 diag	age 12 ty had reported the injury of a skin tear to the State the emergency room ted 4/21/15, identified and ry of unknown origin as more wer leg lacerations. Pt (patient) entimeter) y shaped laceration I leg that is gaping and has fat nt. Unsure of what happen [sic] ation, no falls, possibility a piece. The wound was closed using losure: skin layer: 22 sutures ration was Y- shaped, deep, sion, and measured 19 cm total ation was difficult to repair since thin and there was a large and the ER identified the treated common complex leg laceration. of R43's quarterly Minimum lated 5/8/15, identified R43 as with dependence on staff for civities of daily living (ADL's). w with family member (F)-A on m., F-A discussed an incident ration and expressed concern that m F-A of the outcome of the one whe incident occurred. F-A a large 7 inch plate size area of the floor before R43 was ramedics to the emergency "It looked like a pile of afterbirth hermore, F-A explained R43 in the two aides stood her up, 'my what is the matter with it?' The		226				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		SURVEY PLETED
		245320	B. WING _		07/0	02/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226 F 244 SS=E	pants leg was ther huge "blow out" ac F-A, the emergency speculated that the in the wheel chair pinching was relied. When interviewed administrator ackrinformed of the incomplete stated he had not the file had been conformed of the incomplete stated he had not the file had been conformed of nursing's (DON employ. The admining the report, assistant director on 6/1/15. He vericlarifying document conducted since a former DON had rinvestigation. The the resident who witness statement and no education recurrence of the 483.15(c)(6) LIST GRIEVANCE/RECOMPANCE/RE	in pulled up and revealed the ecording to F-A. According to be proom physician had a calf may have been pinched and when the pressure of the ved, the skin just "blew apart". In on 7/2/15 at 8:25 a.m., the nowledged having been verbally cident on 4/21/15, although seen the incident report until discovered in the former director office after she'd left their inistrator stated that upon it had been signed by the of nursing (ADON) and himself fied there had been no further not followed through with the re had been no statements from was cognitively intact, no tes, no environmental review, and/or training to prevent incident. EN/ACT ON GROUP COMMENDATION or family group exists, the facility views and act upon the ecommendations of residents erning proposed policy and ons affecting resident care and	F 22			8/11/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
FORM CMS-2	Based on interview facility failed to follo council concerns re which had the pote reviewed; R77, R9 Findings include: Review of Residen Minutes, dated 4/2 "Long call light time shipment of radios process of marking distributed to staff" light wait times." O Meeting Agenda ar Business "Long ca "New shipment of addressed in nurse and education of s and date included situation and education. Add 5/21." The minutes resident satisfactio progress. The Res and Minutes for 6/3 on call light wait time requiring continued 5/19/15 minutes. Family Townhall M "2. Nurses/aide rel teamwork. They are they aren't on their Timely call light time meal times. 4. Aide there an incentive	w and document review, the ow up on family and resident regarding call light wait times intial to impact 6 of 6 residents of R11, R52, R115 and R64. It Council Meeting Agenda and 1/15, revealed in new business is with an action plan "new was received, we are in the of them and getting them. This should help with the call in 5/19/15 the Resident Council of Minutes noted in Old ill light time" with the action radios was received, will be and nurse's aide meetings, taff on spot audits." Resolution "Ongoing monitoring of the action of staff. Continuing date ressed in meetings on 5/20 and action of staff. Continuing date ressed in meetings on 5/20 and action tinclude comments on on with call light wait time ident Council Meeting Agenda 23/15, did not include follow up nes, despite being noted as did action and monitoring on the inutes, dated 5/21/15, revealed ationship-seems to be no ren't responding to residents if twing or if it's not their job. 3. nes, long call light time during the shide on the weekend, is for them to not do so?" The "Customer Service rounds are		F#	The preparation of the following ple correction for this deficiency does reconstitute and should not be interpleas an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exsolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#77, R#9, R#1 R#52, R#115 & R#64 patterns of corresponse times were assessed to determine care times, medication schedule, and activity preferences reducing the need to call and wait assistance. b) All staff will receive re-edcuation responding to call lights in a timely manner and turning off the call light entering the room to meet individual needs. c) All staff will be re-educated on the process for following up with concentry from resident/family council meeting the facility's interdisciplinary tea (IDT) will audit via resident intervie observations and/or call logs. Any light identified as excessive will be investigated. e) Results of these audits will be documented in the facility's quality	not reted by the red on ent of necuted visions waiving retail light for for all neerns ngs.	Page 15 of 44

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE COMF	SURVEY PLETED
		245320	B. WING_			07/0	2/2015
	PROVIDER OR SUPPLIER /N HEIGHTS HEALTH	ICARE CENTER		STREET ADDRESS, CITY 2060 UPPER 55TH STI INVER GROVE HEIO	REET EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	teamwork. Upcomi June. 3. Continuing Customer Service that helps with this radio system in pla effectively. 4. There weekends. Encour well as fill out a fee nurses if this occur [evening/afternoon purchased should more recent meeting. The facility failed to call light wait time. A review of R77 arrevealed R77 was extensive assistant toilet use and persodependent on staff. On 7/1/15 at 3:15 provided by the several minutes for to help move his lead a window closed were ported he had specurrent and former light wait times. Or again confirmed he significant amount with getting his leg reported call light of with not enough do a review of call light revealed R77 waits	ontinue to re-educate staff on ng staff training scheduled for g to work on this issue, again, rounds are being done and issue, and we have a new ce to communicate more e is a Manager on Duty on the aged to speak with them, as edback form. Talk with the rs in the PM]. New radio that were recently help as well." There were no ngs for Family Townhall. of follow up on concerns related these for R77. Innual MDS, dated 5/15/15 cognitively intact and required ce for bed mobility, dressing, onal hygiene and was totally	F 24	assurance meet IDT for 3 month	ting and reviewed bas.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245320	B. WING			07/0	2/2015	
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077			
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F 244	6/21, morning of 6 6/23, morning and afte evening on 6/15,	id/22, twice on the morning of id/26 and morning of 6/27. It of follow up on call light wait R9. It quarterly Minimum Data Set 15 further confirmed R9 stance to meet basic needs we assistance required for bed locomotion on unit, dressing, sonal hygiene. R9's 5/5/15 ther revealed she was ively impaired and was nent of urine and bowel. 1 p.m. a family member of R9, aff were not responding to call sonable time. F-B reported she wait over an hour for help. F-B ides don't care and don't come -B added R9 wore a disposable ff were not answering call lights me and R9 had waited in soiled ed she believed part of the e been staff not communicating hen they went on breaks and e worn the walkie system used all lights. F-B reported extended curred on various shifts and had ly basis. F-B reported she		244				

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE COMF	SURVEY
	245320	B. WING			07/0	2/2015
PROVIDER OR SUPPLIER 'N HEIGHTS HEALTH			2	060 UPPER 55TH STREET EAST		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
morning of 6/24. The facility failed to times for R11. R11's most recent revealed he was cextensive assistant. On 6/29/15 at 6:08 waited over an hot transferring and for incontinence cares "disgusted." R11's call light receive reviewed. R11 waited following instance afternoon of 6/24/afternoon of 6/27/ The facility failed to time concerns for R52's most recent she was cognitive assistance with to On 6/29/15 at 3:34 see I shouldn't go can't wait I have a how long she wait responded "some Review of R52's co 6/27/15, revealed light times over 30.	annual MDS, dated 5/23/15, ognitively intact and required ice for toileting and transferring. B p.m. R11 reported he has sur for assistance with reassistance with toileting and s. R11 noted he was ord for 6/21/15 to 6/27/15 was ted over 30 minutes on the set the morning of 6/21/15, the 15 and the morning and the 15. o follow up on call light wait R52. t MDS, dated 4/10/15, revealed by intact. R52 required extensive illeting and transferring. 4 p.m., R52 reported "well you to the bathroom by myself, but I little bladder" and when asked ed with her call light on, R52 times it seems like forever." sall light record for 6/21 to the following instances of call minutes: the morning of		244			
0/21/15 and the a	ILEMPORT OF O/27/13.					
	ROVIDER OR SUPPLIER N HEIGHTS HEALTH SUMMARY ST. (EACH DEFICIENCE REGULATORY OR IT Continued From particular for R11. R11's most recent revealed he was concerned assistant on 6/29/15 at 6:08 waited over an host transferring and for incontinence cares "disgusted." R11's call light reconcerned in the reviewed. R11 waited lowing instances afternoon of 6/24/afternoon of 6/24/afternoon of 6/27/ The facility failed to time concerns for R52's most recent she was cognitive assistance with to On 6/29/15 at 3:34 see I shouldn't go can't wait I have a how long she wait responded "some Review of R52's concerned as some	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 morning of 6/24. The facility failed to follow up on call light wait times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance for toileting and transferring. On 6/29/15 at 6:08 p.m. R11 reported he has waited over an hour for assistance with transferring and for assistance with toileting and incontinence cares. R11 noted he was "disgusted." R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/21/15, the afternoon of 6/24/15 and the morning and the afternoon of 6/27/15. The facility failed to follow up on call light wait time concerns for R52. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with toileting and transferring. On 6/29/15 at 3:34 p.m., R52 reported "well you	ROVIDER OR SUPPLIER **N HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 morning of 6/24. The facility failed to follow up on call light wait times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance for toileting and transferring. On 6/29/15 at 6:08 p.m. R11 reported he has waited over an hour for assistance with transferring and for assistance with toileting and incontinence cares. R11 noted he was "disgusted." R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/21/15, the afternoon of 6/24/15 and the morning and the afternoon of 6/27/15. The facility failed to follow up on call light wait time concerns for R52. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with toileting and transferring. On 6/29/15 at 3:34 p.m., R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when asked how long she waited with her call light on, R52 responded "sometimes it seems like forever." Review of R52's call light record for 6/21 to 6/27/15, revealed the following instances of call light times over 30 minutes: the morning of	ROVIDER OR SUPPLIER IN HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 morning of 6/24. The facility failed to follow up on call light wait times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance for toileting and transferring. On 6/29/15 at 6:08 p.m. R11 reported he has waited over an hour for assistance with toileting and incontinence cares. R11 noted he was "disgusted." R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/21/15, the afternoon of 6/24/15 and the morning and the afternoon of 6/27/15. The facility failed to follow up on call light wait time concerns for R52. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with toileting and transferring. On 6/29/15 at 3:34 p.m., R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when asked how long she waited with her call light on, R52 responded "sometimes it seems like forever." Review of R52's call light record for 6/21 to 6/27/15, revealed the following instances of call light times over 30 minutes: the morning of	ROVIDER OR SUPPLIER N HEIGHTS HEALTHCARE CENTER NEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 morning of 6/24. The facility falled to follow up on call light wait times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance for toileting and transferring. On 6/29/15 at 6:08 p.m. R11 reported he has waited over an hour for assistance with transferring and for assistance with transferring and for assistance with tolleting and incontinence cares. R11 noted he was "disgusted." R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning and the afternoon of 6/24/15 and the morning and the afternoon of 6/24/15 and the morning and the afternoon of 6/24/15 and the morning and the afternoon of 82. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with tolleting and transferring. On 6/29/15 at 3:34 p.m., R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when an asked how long she waited with the rcall light on, R52 responded "sometimes it seems like forever." Review of R52's call light record for 6/21 to 6/27/15, revealed the following instances of call light times over 30 minutes: the morning of	ROVIDER OR SUPPLIER N HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEPLICIPIES (EACH DEPCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 The facility failed to follow up on call light wait times for R11. R11's most recent annual MDS, dated 5/23/15, revealed he was cognitively intact and required extensive assistance of 6/24/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/27/15, revealed the follow up on call light wait time concerns for R52. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 required extensive assistance with toileting and the afternoon of 6/27/15. R52's most recent MDS, dated 4/10/15, revealed she was cognitively intact. R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when asked how long she waited when recall light record for 6/21 to 6/27/15, revealed the was cognitively intact. R52 reported "well you see I shouldn't go to the bathroom by myself, but I can't wait I have a little bladder" and when asked how long she waited with her call light no, R52 responded "sometimes it seems like forever." Review of R52's call light record for 6/21 to 6/27/15, revealed the following instances of call light trecord for 6/21 to 6/27/15, revealed the following instances of call light trecord or 6/21 to 6/27/15, revealed the following instances of call light trecord sover 30 minutes: the morning of

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMF	PLETED
		245320	B. WING	i		07/0	2/2015
	PROVIDER OR SUPPLIER	ICARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244	Review of R115's ridated 4/21/15, reve cognitive impairmed assistance for bed toilet use and person on 6/30/15, at 10:38 R115, (F)-C, report when R115 was in waited 30 minutes. Review of R115's 6/27/15 revealed to over 30 minutes: the facility as not response times as desk. The facility had investig the previous week concern to the fact reach a conclusion information from the was requested and there was nothing. On 7/2/15, at 10:0 [DON] and adminiting regular review of concern to the fact response issues be facility had investig the previous week concern to the fact reach a conclusion information from the was requested and there was nothing. On 7/2/15, at 10:0 [DON] and adminiting and administrator have closely moniting monitorial regular review of concern to the fact regular revie	most recent admission MDS, ealed R115 had severe mobility, transfers, dressing, onal hygiene. 37 a.m. a family member of ted she had put her call light on the bathroom and sometimes for staff to help. call light record for 6/21 to be following wait times were be evenings of 6/21 and fternoons of 6/22, 6/23 and a.m. the administrator reported a regularly checking call light each could not print it out at her had worked on call light yordering new walkies. The gated call light wait times from after surveyor brought the illity's attention, but could not he resident council concerns d the administrator reported		244			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>	X3) DATE COMP	SURVEY LETED
		245320	B. WING			07/0	2/2015
	ROVIDER OR SUPPLIER	CARE CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 160 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 244 F 253 SS=D	with attending residents shat answered in a time adequately address stated staff ignore go off for a call light seeing staff sleeping cards at the table at call light beepers. If acility staff of these issues had been discouncil meetings, resident council meetings, resident council meeting, be change." 483.15(h)(2) HOUS MAINTENANCE SEED The facility must purpose and seed to the seed to	y intact, expressed frustration dent council meetings because, are how call lights are not being ally fashion the facility failed to as the residents concern. R64 the walkie talkies when they at R64 expressed personally ag on the couches or playing at 5:00 a.m. and turning off the R64 stated they had informed be issues and knew call light iscussed at several resident R64 stated, "Going to the detailed the settings is a meet, eat, and accause things discussed do not SEKEEPING &		253			8/11/15
	by: Based on observative review, the facility was free of odors a condition for 2 of 2 for room odors. Findings include: When interviewed stated an odor was really smells ripe i	ention, interview and document failed to ensure the bathroom and kept in a cleanable residents (R65, R51) reviewed on 6/30/15, at 10:46 a.m. R65 is noted in the bathroom, and "it in there." At this time a stale ted in the bathroom.			The preparation of the following pla correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement of facility of the truth of the facts alleged conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exessolely because it is required by proving State and Federal law. Without with the foregoing statement, the facility that:	ot eted by the ed on nt of ecuted visions vaiving	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		245320	B. WING			07/0	2/2015
	ROVIDER OR SUPPLIER			20	REET ADDRESS, CITY, STATE, ZIP CODE 60 UPPER 55TH STREET EAST VER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	Continued From p	age 20	F2	:53			
	R51 were noted to urine. The director [DES] reported the chronic issue. The informed him they the gentlemen in twhen urinating. The with the grout of time the backsplar away from the walfinding. The 7 Step Daily Valed 1/1/2000, di Supplies.", "2. Em 4. Clean and Saniand Sanitize the Complex of the step o	5 a.m. the bathroom of R65 and a have a strong odor of stale of environmental services odor from the bathroom was a DES stated housekeeping had clean the bathroom, and then he room miss the toilet bowl he DES reported the issue may on the floor or the toilet. At this is against the sink was coming I and the DES confirmed this Washroom Cleaning procedure, rected staff "1. Check pty Trash", 3. Dust Mop Floor", tize Sink and Tub", "5. Clean commode.", "6. Spot Clean tions" and "7. Damp Mop			 a) With respect to R#51 and R#65 bathroom has been thoroughly cleaned back splash was repaired. b) Cleaning procedure has been reand revised. c) Housekeeping staff will receive re-education on the cleaning proced d) Healthcare Services Manager/Designee will audit 3 resirooms per week for 8 weeks to encleanliness. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed if for 3 months. f) ED/Designee is responsible for completion. 	eviewed edures. dent sure	
F 280 SS=D	483.20(d)(3), 483 PARTICIPATE PL	.10(k)(2) RIGHT TO ANNING CARE-REVISE CP	F	280			8/11/15
	incompetent or ot incapacitated und	the right, unless adjudged herwise found to be er the laws of the State, to ning care and treatment or and treatment.					
	within 7 days afte comprehensive a interdisciplinary to physician, a regis	care plan must be developed r the completion of the ssessment; prepared by an eam, that includes the attending tered nurse with responsibility nd other appropriate staff in					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 1060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES 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 280	disciplines as deter and, to the extent p the resident, the re legal representative	age 21 rmined by the resident's needs, oracticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F2	280			
	by: Based on docume facility failed to rev 1 of 1 residents (R positioning and fail of 1 resident (R69) Findings include: R43's care plan was change for restora R43's care plan da mobility "Limited pright humeral arm history and history Requires 2 staff as R43's admission N 2/13/15, indicated was dependent on (ADL's). R43 was discharge 4/10/15, with a not 15 feet with L hall care giver assistar	ent review and interview, the fiew and revise the care plan for 43) for ambulation and ed to revise the care plan for 1 for refusing weights. The sent updated to reflect a tive nursing ambulation. The sent updated to reflect a tive nursing ambulation. The sent updated to reflect a tive nursing ambulation. The sent updated to reflect a tive nursing ambulation. The sent updated to reflect a tive nursing ambulation. The sent updated to reflect a tive nursing ambulation. The sent updated to reflect a tive nursing ambulation. The sent updated to reflect a tive nursing ambulation. The sent updated to reflect a tive nursing ambulated to a tive nursing ambulated and staff for activities of daily living the sent updated to "ambulate realing on even surfaces with nursing on even surfaces with nursing on the sent updated to "ambulate realing on even surfaces with nursing on even surfaces with nursing on the sent updated to the sent up			The preparation of the following p correction for this deficiency does constitute and should not be interp as an admission nor an agreemen facility of the truth of the facts alleg conclusions set forth in the statem deficiencies. The plan of correction prepared for this deficiency was expolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#43, a compress assessment was completed. Care was updated to reflect current amband repositioning care needs. b) With respect to R#69, care plant been reviewed and revised to reflect refusal of cares. c) Licensed staff will receive re-ed on reviewing and revision of the C Plan. d) The DNS/Designee will audit 2	not preted to by the ged on ent of the couted ovisions waiving y states thensive explan coulation in has ect the coulation are the coulati	
FORM CMS-2	2567(02-99) Previous Version	is Obsolete Event ID:1RUJ	11	F	acility ID: 00829 If continua	tion sheet	Page 22 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245320	B. WING	_	**************************************	07/0	2/2015	
	PROVIDER OR SUPPLIER /N HEIGHTS HEALTH	ICARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077	T EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	ambulate x 300 feet walker) with MOD of independently in eifacility) or SNF (ski Furthermore, the difference of the independent in facility) or SNF (ski Furthermore, the difference of the independence of th	age 22 et with FWW (front wheeled (moderate) (1) in order to live ther ALF (assisted living illed nursing facility)." ischarge summary read, to some of the nursing staff." also directed staff; "[R43] has ment to skin integrity and elopment with actual pressure t (related to) advanced age, nence, functional decline, by, edema, and requiring d mobility, transfers, hygiene, "he Intervention read, tion/position changes during Rounds." There were no other o positioning in the wheel chair eposition every 2 hours when 0 minutes when up in shift. Start date 4/2/15." Ition on 6/29/15, at 4:45 p.m., the dining room table. R43 er socks, and there were no wheel chair. R43 was not change position from the staff ation period from 4:45 p.m. until stion from 7/1/15 from 7:00 a.m. as was seated in a wheel chair at ator. At 7:30 a.m. R43 was ing room for breakfast. At 8:30 eteled to the bedroom. At 8:40 a.m., relevant to the bedroom. At 8:40 a.m., relevant to the property of the staff assistance, was transferred to the pedroom. At 8:40 a.m., relevant to the pedroom.		280	care plans per week for four weeks resident care plan per week for four weeks for ambulation, repositioning and refusal of care. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed to for 3 months. f) DNS/Designee is responsible for completion.	ir g needs by IDT		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245320	B. WING	ā	07	/02/2015
	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, Z 2060 UPPER 55TH STREET EAS INVER GROVE HEIGHTS, MI	ST .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 280	6:30 a.m. into the offers to change per during this two houtime. NA-A, acknowsheet did not specand stated NA-A where informed the change every 30 no validated R43 was position while seat when settled into be creases and crevio buttocks area from numerous red created posterior thighs incontinent of uring with the dressing of buttock.	NA)-A, verified R43 was up at wheelchair and there were no osition or offload buttocks, ar and ten minute period of wledged the aide assignment ify half hour position changes worked full time and had never to R43 required a position ninutes. Furthermore, NA-A not able to physically change ed. Observation of R43s' skin at 8:45 a.m., revealed reduces to posterior thighs and the brief. NA-A verified the asses and crevices were present and buttocks. R43 was not eat this time. LPN-A proceeded change to the superior right		280		
	nursing assistant (6:30 a.m. into the offers to change p during this two hot time. NA-A, acknowsheet did not speciand stated NA-A whose the informed that change every 30 r validated R43 was position while sea. Interview on 7/2/1 who worked full time aware R43 was to	d on 7/1/15, at 8:40 a.m., (NA)-A, verified R43 was up at wheelchair and there were no osition or offload buttocks, ur and ten minute period of tweedged the aide assignment sify half hour position changes worked full time and had never at R43 required a position minutes. Furthermore, NA-A is not able to physically change ted. 4, at 11:00 a.m., with NA-B, me, also verified not being have a position change every seated, and validated the aide				

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	2/2015
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	R43's position ever R69 plan of care with R69's refusal of care with R69's refusal of care with R69's refused in point cling gain 3 lbs/24 hrs (albs/week or wgt exweight (414.4 lbs)), administration recurefused to be weight (414.4 lbs). The refused to be weight (414.4 lbs), administration recurefused to be weight (414.4 lbs). The refused to be weight R69's May 2018 refused to be weight Review of R69's particular aphysician order [continuous position keep airways open lbreathing problem [hour of sleep] off	did not inform staff to change ry half hour. It is not updated to include are. Inedical record indicated a redaily am (morning) weights. ck. Notify MD for wgt (weight) gounds in 24 hours) 5 acceding 10 lbs from admission red (MAR) indicated R 69 and the every day in June. Review of MAR indicated the resident all but two days. In the dall but two days. In the day of the medication or the following "CPAP are airway pressure (used to h, used by people who have is, such as sleep apnea)] on HS AM: Heated humidifier, full		280			
F 309 SS=D	tubing. Pressure need: Indefinite. MR69's June MAR every day in June When interviewed licensed practical refused to get out weights, and refus LPN-C verified R6 the plan of care, a 483.25 PROVIDE	on 7/2/15, at 10:27 a.m. nurse (LPN)-C stated R69 of bed daily, refused daily sed to wear the CPAP at night. 69's refusal of care was not on and should have been. CARE/SERVICES FOR		309			8/11/15

PRINTED: 12/08/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245320	B. WING			07/02/2015	
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER				20	REET ADDRESS, CITY, STATE, ZIP CODE 60 UPPER 55TH STREET EAST VER 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Each resident must provide the necess or maintain the hig mental, and psychaccordance with the and plan of care.	st receive and the facility must sary care and services to attain hest practicable physical, osocial well-being, in the comprehensive assessment	F	309			
	by: Based on record realled to ensure can ursing assessme resident (R55) who well, and who expiday. Findings include: Review of Progressen admitted to tadmitting diagnose obstruction, diabeta bipolar disorder, and A late entry Progresincluded; "Shortly the resident unrespulse and not breathis vitals which we were taken due to previous night" Review of the reconursing assessmenticluding; recent were taken to the reconursing assessmenticluding	review and interview, the facility re, including a thorough nt, was provided for 1 of 1 o complained of not feeling red unexpectedly the following red unex			The preparation of the following pla correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement of facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exessolely because it is required by proving of State and Federal law. Without with the foregoing statement, the facility that: a) With respect to R#55, the nurse responsible for failing to document a change of condition is no longer emat the facility. b) Licensed staff will receive re-educed on documenting a resident's change condition. c) DNS/Designee will audit 2 resident records for change in condition per for 4 weeks then 1 resident record present the sale of these audits will be seen the sale of these audits will be	ot eted by the ed on nt of ecuted risions vaiving states a ployed uation e in nt week	

Facility ID: 00829

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/02/2015	
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER				20	REET ADDRESS, CITY, STATE, ZIP CODE 60 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311 SS=D	documentation in There was no doc pulse, or respiration pressure document was only one oxygand that had occur note from a nurse indicated the residuated for this residuated for this residuated regarding to R55's unexpect 483.25(a)(2) TRE IMPROVE/MAINT A resident is given services to maintain specified in paragonal This REQUIREMI by: Based on observices to maintain the resident is given services to maintain specified in paragonal This REQUIREMI by: Based on observices to maintain the resident is ability to (R43) reviewed for the respiration in the resident's ability to (R43) reviewed for the resident's ability to (R43) reviewed for the resident in the resident's ability to (R43) reviewed for the resident in the resident's ability to (R43) reviewed for the resident in the resident's ability to (R43) reviewed for the resident in the resident	Progress Notes after 4/21/15. umentation of temperature, on after 4/18/15, and no blood ntation after 4/24/15. There gen saturation level documented rred on 4/16/15. An acute visit practitioner, dated 4/24/15, lent had been seen for "coarse of not feeling well the night of ed unexpectedly on 4/26/15. I on 7/1/15, at 8:32 a.m. the grown of assessment could be the events that occurred prior ted death. ATMENT/SERVICES TO TAIN ADLS In the appropriate treatment and ain or improve his or her abilities raph (a)(1) of this section. ENT is not met as evidenced atton, interview and document of ambulate for 1 of 1 resident	F3	311	documented in the facility's quality assurance meeting and reviewed b for 3 months. e) DNS/Designee is responsible for completion		8/11/15
	Findings include:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	02/2015
	PROVIDER OR SUPPLIER			206	REET ADDRESS, CITY, STATE, ZIP CODE 60 UPPER 55TH STREET EAST VER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	facility on 2/6/15, for the right humerus interagency transf admission, R43 has the assisted living. A fourteen day min assessment dated in the corridor durperiod, and had worder and the bedroom twice duperiod. A review of the phastitled, Physical Thas 2/6/15, included; narrow base quad CGA (care giver a functioning Ambul quad cane on every assist secondary balance). Goal data cording to the flower independent assisted living set fracture secondary PT Discharge Surprovided to some program." The colidentified as; "Am	mitted from an assisted living collowing a fall and fracture of (upper arm). According to er documentation at the time of ad been ambulating 300 feet at an according to the therapy goals. In a coording to the therapy documentation the coordinate of the coordinate	F	311			

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	245320		B. WING			07/02/2015			
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER				20	REET ADDRESS, CITY, STATE, ZIP CODE 60 UPPER 55TH STREET EAST VER 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		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 311	FMP (full mobility patherapy "Goal" inclified food for the rapy "Goal" inclified food food food food food food food fo	d in walking with patient for potential)." The physical cuded; "ambulate 300 feet with ed walker) with MOD reder to live independently in d living facility) or SNF (skilled ting." It is from 4:45 p.m 6:00 p.m. on not offered assistance or stand or walk. At 5:15 p.m., the dining room table wearing no foot pedals on the wheel It ion 7/1/15 from 7:00 a.m. untiles seated in a wheel chair by a later. At 7:30 a.m. R43 was larger from for breakfast. At 8:30 leeled back to her bedroom. At a lobserved during a transfer. It to tolerate standing for 30 lating, "that's enough!" R43 was lansfer to her bed with the last fifth, nursing assistant (NA)-A. Lation, NA-A verified at 8:40 a.m. transferred into the wheelchair at an esistance to ambulate. NA-A lation, the herself worked full time d not walked or attempted to mission/re-admission. 1)-A was present during the 8:40 a.m., and acknowledged mbulate R43. F-A stated,		311					

	ATEMENT OF DEFICIENCIES DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245320	B. WING _		07	/02/2015		
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 311	and said she was ability to walk. Du expressed a desireturning to the assertance of the analysis of the assertance of th	prior to the fractured right arm, afraid R43 would lose her ring this conversation, R43 re to be walked in hopes of ssisted living. Ew on 7/2/14, at 11:00 a.m., with I time staff, she stated she did as supposed to ambulate. Ew with licensed practical nurse to at 11:30 a.m., she verified she would take steps, but did not an ambulation program for R43. Stered nurse (RN)-C was accepted to a sextensive assisting in the room, and verified R43 at hallway five of the seven during an assessment review 2/17/15. The review revealed R43 had been a hospital for surgical repair of the sture on 3/12/15. Upon return, the 5 day MDS dated 3/22/15, dated 3/29/15, and the 30 day (15, all indicated there had been the bedroom or hallway during periods. The of R43's quarterly Minimum dated 5/8/15, identified R43 as with dependence on staff for		11				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245320	B. WING		07/02/2015
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 311	physical therapy possible the nurs completed and p expressed trainin ambulate R43 us in the hallway. When interviewe expressed not kr	d on 7/2/15, at 1:12 p.m., the assistant (PTA) thought it was sing referral sheet had not been assed on to the nurse. The PTA ag two nursing assistants to sing the left arm and the handrail d on 7/2/15, at 1:20 p.m., RN-A nowing R43 could walk and	F3	:11	
	because nursing referral from the Additional inform	he process had been "dropped" had not received the rehab therapy department. The action was submitted by the prof the facility, after survey, July			
	since her admiss to right humeral repair of the hum the RUE [right up	ambulate had been inconsistent sion due to instability secondary fracture, then due to surgical neral fracture with restrictions of oper extremity] and then with a stion to her LLE [left lower dema."			
	has never ambu admission. She ambulate in her of one staff. She participate consi discharge from participate sharper from participate with staff assista	ocumentation shows that R43 lated in the hallway since her has been inconsistent but does room with extensive assistance maintains her ability to stently in her bed mobility. Upon physical therapy 4/10/2015 R43 her goal of ambulation 50 feet ance but was ambulating a set with contact guard			

	ATEMENT OF DEFICIENCIES AD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	X3) DATE SURVEY COMPLETED		
		245320	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	7/7/2015 for gait to program. On 7/7/2 level of function is feet on even surfalleft handrail and right on therapies arm. function demonstrimprove and did nowalking program of currently receiving mobility". 483.25(c) TREAT PREVENT/HEAL Based on the concesident, the facilia who enters the fadoes not develop individual's clinical they were unavoid pressure sores reservices to promo prevent new sore This REQUIREM by: Based on observers.	s referred to therapies on raining and to initiate a gait 2015 Resident (R43) current noted that she ambulates 15 does with minimal assist using ght upper extremity supported Resident's current level of rates that she continues to ot have a loss of ability. A has been put in place. R43 is a pain medication to promote	F 314		an of	8/11/15
	repositioning to 1 assessed to be a	of 1 resident (R43) who was trisk for developing pressure oped a pressure ulcer after facility.		constitute and should not be interpreted as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was expected by because it is required by pro-	reted by the ed on ent of n ecuted	

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245320 B.					07/02/2015	
NAME OF PROVIDER OR SUPPLIER WOODLYN HEIGHTS HEALTHCARE CENTER				20	REET ADDRESS, CITY, STATE, ZIP CODE 160 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	R43 was admitted facility, due to a no humerus (upper ar splint to the right and Document review of Data Set (MDS) day was cognitively into activities of daily livindentified R43 was pressure ulcers. The first document an unstageable properties and no pressure ulcers. The first document an unstageable properties and readmorning by the attention assistant/registere [R43's] right gluteat measures 1.5 cm (Medial) measures (Posterior) measures (Posterior) measures (Posterior) measures applied to Superior applied to medial and unstageable, dark #2 and #3 beefy repain with dressing get official treatment. The next wound donotes was made or read; "[R43] right to open areas. The novered with thick surrounded by been blancheable. Media shearing. Allevyn placed atop super	2/6/15, from an assisted living n-repaired fracture of the right m,) with instructions to wear a rm with limited mobility. of R43's admission Minimum ated 2/13/15, indicated R43 act and was dependent with ring (ADL's). The MDS is at risk for the development of the every near the sure ulcers identified. Attaction that identified R43 had describe ulcer was 3/1/15, at at at a light many light may be a light m	F3	114	of State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#43 a compret assessment has been performed. plan has been reviewed and revise related to repositioning. Wound treand monitoring was initiated with the discovery of the pressure area. And continues to show improvement. b) Residents have a comprehensing assessment completed upon admit quarterly and with a significant chance. Nursing staff will receive re-edoc related to care plan interventions, repositioning, and skin observation. d) DNS/Designess will audit 2 residence and repositioning for 4 weeks. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed for 3 months. f) DNS/Designee is responsible for completion.	rensive Care ed eatment ne eatment ne estate in the real extra from the real extra fro	

IDENTIFICATION NUMBER		' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIER			20	REET ADDRESS, CITY, STATE, ZIP CODE 160 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	protect skin. [R43] the areas palpated ask am staff tomo Allevyn and Skin p. The form titled Me (MAR) dated 3/1/1 Allevyn Gentle Bowound) change evenecessary) on 3/4 medication sheet medial and inferio Apply every shift. MAR on 3/4/15, 3-1	denies discomfort with any of dor treatment performed. Will prow to call for orders for the prep orders." dication Administration Record 5-3/31/15, begins to sign out order to (R) buttock (Superior Pery 3 days and prn (whenever 15. The next direction on the stor 4 layers skin prep to a rareas of shearing (R) buttock. This is first signed out on the	F	314			
	9:42 a.m. and the being seen at the coccyx wound." T tissues were shar cm (centimeter) o tissue was removi formation, stimula overall bacteria lo decrease edge se	physician note read, "[R43] is Vascular Clinic today regarding he epidermal and dermal ply debrided for a total square f 10. Devitalized and non viable ed to improve granulation tissue te wound healing, decrease ad, disrupt biofilm formation and					
	4/2/15, identified a	a physician order, "reposition en in bed and every 30 minutes					
	and July 2015, re- when in bed and o wheel chair every Although the treat reposition R43 ev	reatment Record, for June 2015 ad, "Reposition every 2 hours every 30 minutes when up in shift. Start date 4/2/15." thent record directed staff to ery 30 minutes when up in the w of the nursing assistant care			•		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245320	B. WING		and Address of the State of the	07/0	2/2015	
	PROVIDER OR SUPPLIER	ICARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 314	hours. During an observal R43 was seated at was wearing gripper foot pedals on the offered to stand or during the observal 6:00 p.m. During an observal until 7:30 a.m. R43 a table by the elevent wheeled to the din a.m. R43 was whealed to the din a.m. R43 was whealed when internursing assistant (6:30 a.m. into the offers to change play during this two hout time. NA-A, acknows heet did not speciand stated NA-A wheeled informed the change every 30 revalidated R43 was position while seaf when settled into the creases and crevibuttocks area from numerous red creases and crevibuttocks area from numerous red creases incontinent of urin with the dressing obuttock.	tion on 6/29/15, at 4:45 p.m., the dining room table. R43 er socks, and there were no wheel chair. R43 was not change position from the staff tion period from 4:45 p.m. until tion from 7/1/15 from 7:00 a.m. as was seated in a wheel chair at ator. At 7:30 a.m. R43 was ing room for breakfast. At 8:30 teled to the bedroom. At 8:40 taff assistance, was transferred eviewed on 7/1/15, at 8:40 a.m., NA)-A, verified R43 was up at wheelchair and there were no osition or offload buttocks, ar and ten minute period of wledged the aide assignment if yhalf hour position changes worked full time and had never at R43 required a position innutes. Furthermore, NA-A is not able to physically change ted. Observation of R43s' skin bed at 8:45 a.m., revealed red are to posterior thighs and in the brief. NA-A verified the ases and crevices were present and buttocks. R43 was not e at this time. LPN-A proceeded change to the superior right		314				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		E SURVEY MPLETED
		245320	B. WING	No. of the second secon	07	/02/2015
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN	r	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	and documentation which read; "1.6 or granulation tissue probing of wound 2 gauze pad cut in acid. Placed in which and secured The largest measure and secure and	coage 35 on from the Skin/Wound note of 1 x 0.2 cm (centmeter) 100% on No tunneling noted with gentle bed. Cleansed. Patted Dry. 2 x n half and moistened with acetic bound bed. Covered with ABD with hypafix tape." Surements for the right superior ed in the progress notes 2.5 cm. (centimeter) Depth is Documentation in the progress ne right medial and right inferior nealed 3/18/15. The superior easured on 6/30/15, as 1.6 in x .20 depth in centimeters. Itional care physician sit to R43 on the form titled, and Care for Seniors dated there was no mention of any sues. Furthermore the physician of skin involving buttock staff request referral to wound ade. Additionally, load-off cushion air mattress are to be obtained." The with the director of nursing definition of the indicating specific skin involving specific skin inciated with bathday prior to the und discovery 3/1/15, because nented in the computerized a statement which read, "bruises"		314		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245320	B. WING	i		07/0	2/2015
	ROVIDER OR SUPPLIER	ICARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	and if there was no other documentation. The undated facilit	e admission right arm fracture, o skin issue, there would be no on. y policy, titled, Comprehensive	F	314			
	Defined Assessme because the facility there were wounds Interview on 7/2/14 who worked full tin aware R43 was to	ng Evaluation UDA (User ent) was not used for R43 y did not use the form until s, according to the DON. 4, at 11:00 a.m., with NA-B, ne, also verified not being have a position change every seated, and validated the aide					
F 329 SS=D	R43's position eve 483.25(I) DRUG R UNNECESSARY I Each resident's dr unnecessary drug drug when used in duplicate therapy) without adequate i indications for its u adverse conseque	ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose d or discontinued; or any	F	329			8/11/15
	resident, the facilit who have not used given these drugs therapy is necessar as diagnosed and record; and reside	rehensive assessment of a ty must ensure that residents d antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical ents who use antipsychotic dual dose reductions, and					

PRINTED: 12/08/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING	·		07/0	2/2015
	PROVIDER OR SUPPLIER			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 YY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	behavioral interver	age 37 ntions, unless clinically an effort to discontinue these	F	329			
	by: Based on record residents (R1, R6; have monitoring of related to the use clonazepam for R orders were follow Findings include: Record review revorder for clonazepat at bedtime for par medication admin and July, 2015, recurrently receiving administration recurrently read, "Targe agitation" There behavior listed. T target behavior recurrent plan of ca	vealed a 5/12/15, physician's pam 1 milligram (mg) by mouth anoid schizophrenia. The istration records for June, 2015 evealed the resident was go this medication. The treatment cords for June, 2015 and July, at Behavior #1- (Clonazepam) evere no details of this there was no reference to a elated to clonazepam use on the refor this resident. If on 7/2/15, at 2:04 p.m. nurse (LPN)-C, the nurse unit, was asked what specific nonstrated with agitation. She d cares, could be delusional,			The preparation of the following pleorrection for this deficiency does a constitute and should not be interpleas an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was expolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#1, resident's applications and blood pressure parameter were reviewed with MD. b) With respect to R#69, resident's sugar and blood pressure parameter were reviewed with MD. c) All residents receiving psychoacomedications have been reviewed to assure that there are appropriate indications for the use of these medications and that target behavildentified. Care plans undeted as identified.	not reted t by the ged on ent of n decuted divisions waiving y states care ed to s s blood ters ctive to	

Facility ID: 00829

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		245320	B. WING	i		07/0	2/2015
	ROVIDER OR SUPPLIER		2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		NVER 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	ensuring adequate Review of R69's M 7/1/15, indicated a accuchecks, call M (nurse practitioner) or greater that 400 administration reco indicated fifteen re- been recorded. Ho notes for the montl indication of MD or glucose readings of Review of R69's M 7/1/15, indicated a Tartrate [medication mg 8a and 8p hold pressure] less thar for June, 2015 indi pressure was 109/ not held. There wa had been retaken for June, 2015, lac the low blood pres When interviewed LPN-C verified the results and indicat nurse to call the M greater than 400. blood pressure rea the expectation wa medication per pa low blood pressure	prod lacked documentation monitoring of medications. edication Review Report dated physician order for ID (doctor of medicine) or NP of the blood glucose less than 75 or New Medication ord (MAR) for June, 2015 adings greater than 400 had wever, a review of progress of June, 2015, lacked or NP notification of blood greater than 400. Idedication Review Report dated physician order for "Metoprolol on for high blood pressure] 50 or SBP [systolic blood on 110." Review of R69's MAR dicated on 6/26/15, R69's blood of 76, and R69's medication was usen odocumentation the BP and review of progress notes sked documentation regarding sure or of any follow-up. on 7/2/15, at 10:27 a.m., a June, 2015, blood glucose ed the expectation was for the ID when the blood glucose was LPN-C also verified the low adding on 6/26/15, and indicated as for the nurse to hold the rameters, and follow up on the		428	d) Licensed staff will receive re-educe regarding the use of psychoactive medication. e) Licensed staff will receive re-educed on notification of MD. f) DNS/Designee will audit 2 resident records for target behaviors per week 4 weeks then 1 resident record for 4 weeks. g) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by for 3 months. h) DNS/Designee is responsible for completion.	cation nt ek for 4	8/11/15
F 428 SS=D	1		F	4 40			0/11/10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIER			20	REET ADDRESS, CITY, STATE, ZIP CODE 60 UPPER 55TH STREET EAST VER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	reviewed at least of pharmacist. The pharmacist me the attending physical pharmacist me the attending pharmacist me the atten	age 39 of each resident must be conce a month by a licensed nust report any irregularities to sician, and the director of e reports must be acted upon.	F4	128			
	by: Based on docum facility's consulting facility of irregular specific target bel anti-anxiety medio reviewed for unner Findings include: Record review recorder for clonaze milligram (mg) by schizophrenia. The records for June, R1 was currently treatment administand July, 2015 re (Clonazepam) ag of this behavior lia a target behavior the current plan of	ent review and interview, the g pharmacist did not advise the ities regarding the lack of naviors related to the use of an eation for 1 of 5 residents (R1) ecessary medications. Vealed a 5/12/15, physician's pam (anti-anxiety medication) 1 mouth at bedtime for paranoid ne medication administration 2015 and July, 2015, revealed receiving this medication. The stration records for June, 2015 ad, "Target Behavior #1-itation" There were no details sted. There was no reference to related to clonazepam use on of care for this resident.			The preparation of the following placorrection for this deficiency does reconstitute and should not be interpolated as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exsolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#1, a medication review was completed by consulting pharmacist. b) All residents receiving psychoacomedications have been reviewed to assure that there are appropriate indications for the use of these medications and that target behavious identified. Care plans updated as	not reted by the ed on ent of necuted visions waiving y states on ed on	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	2/2015
	ROVIDER OR SUPPLIER	ICARE CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 428	behaviors R1 demoreplied R1 refused could not stop talki. The Record of Med dated 5/19 and 6/1 pharmacist had review however, there we recommendations the lack of specific this resident. During a telephone p.m. the facility's casked if she looked with the use of psy reviewing resident pharmacist replied specific target beh recommendations behaviors. The sur Consultant Pharma Nursing for this resincluded the recomspecific Target Bel other psychoactive taking at that time explained she had facility about this reconsultants for the improving the docutarget behaviors at 483.60(b), (d), (e) LABEL/STORE DI	nit, was asked what specific constrated with agitation. She care, could be delusional, and ng. dication Regimen Review form 8/15, revealed the consulting viewed R1's drug regimen. re no notes or found in the record regarding target behavior of agitation for einterview on 7/2/15, at 2:25 consulting pharmacist was defor specific target behaviors choactive medications when records. The consulting that she did look for the aviors and made to use specific target reveyor mentioned there was a facist Communication to sident on 2/21/15, which mendation to use "patient naviors" for the use of several emedications that R1 was The consulting pharmacist spoken with the staff at the equirement and the nurse of facility stated were working on umentation of appropriate		431	c) Nursing staff will receive re-educe regarding the use of psychoactive medications. d) DNS/Designee will audit 2 resider records for target behaviors per weak weeks then 1 resident record for weeks. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed for 3 months. f) DNS/Designee is responsible for completion.	ent eek for 4 by IDT	8/11/15
	a licensed pharma	acist who establishes a system					5

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIER	ICARE CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
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F 431	controlled drugs in accurate reconcilial records are in order controlled drugs is reconciled. Drugs and biological labeled in accorda professional princily appropriate access instructions, and the applicable. In accordance with facility must store locked compartments controls, and perminave access to the controlled drugs list comprehensive D Control Act of 197 abuse, except whe package drug dist	ot and disposition of all sufficient detail to enable an ation; and determines that drug er and that an account of all maintained and periodically als used in the facility must be nee with currently accepted ples, and include the sory and cautionary ne expiration date when all drugs and biologicals in ents under proper temperature nit only authorized personnel to exeys. Tovide separately locked, and compartments for storage of sted in Schedule II of the rug Abuse Prevention and 6 and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose car		431			
	by: Based on observereview the facility medications were	ENT is not met as evidenced ation, interview and document did not ensure four expired removed from storage for 2 of a reviewed, potentially affecting 822, R40).			The preparation of the following properties correction for this deficiency does constitute and should not be interpased as an admission nor an agreement facility of the truth of the facts alle	not oreted nt by the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	2/2015
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	on 6/29/15, at 12:3 discovered: an oper R8, with an opened prior); an open bot medicine), 200 mill with an unreadable expiration date of 3 Registered nurse (were expired and sidirection label on tunreadable. Review of the medicine on 6/29/15, at 12:5 discovered: an oper R40, with an open prior.) Licensed Practical date and indicated should not be used Review of R8's refor Levemir solution unit subcutaneous diabetes. Review of R22's refored reformed guaifene cough when necessary and prior Review of R40's reformed guaifene cough when necessary and prior Review of R40's reformed guaifene cough when necessary and prior R40's reformed guaifene cough guaifene c	ication cart for the 600 hallway, 5 p.m. the following were on bottle of Levemir insulin for d on date of 5/12/15, (48 days the of guaifenesin (cough ligram (mg) tablets for R22, e direction label, and an 8/15. RN)-B verified the medications should not be used, and the he bottle of guaifenesin was dication cart for the 500 hallway, 53 p.m., the following were en bottle of Lantus insulin for ed on date of 5/22/15. (38 days Nurse (LPN) - E verified the I the insulin was expired and d. cord indicated a physician order on (Insulin Detemir) Inject 28 sly every evening shift for ecord indicated a physician sin tablet 400 mg tablet oral		431	conclusions set forth in the statem deficiencies. The plan of correction prepared for this deficiency was expolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#8, R#22 and an audit has been performed to enthat there no expired medications. b) All facility medicaiton carts will be audited to ensure all expired medication expired medication that the facility's medication expiration procedure. c) Licensed staff will receive re-edication expiration procedure. d) DNS/Designee will audit 1 medicart per week for 8 weeks for expired medications. e) Results of these audits will be documented in the facility's quality assurance meeting and reviwed be for 3 months. f) DNS/Designee is responsible for completion.	n decuted ovisions waiving y states R#40, asure Decaitons ued. Cuation ion ication red	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07/0	02/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 431	March 2015, indicated expiration date of 3 procedure also indicated as a second control of the second control	expiration Procedure dated ated insulin vials had an 30 days after opening. The licated medications would be e date of expiration the	F4	31			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered November 17, 2015

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

Subject: Woodlyn Heights IDR

Provider # 245320 Project # S5320025

Dear Ms. Donahue:

This is in response to your e-mail received on August 28, 2015, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F310 where corresponding state licensing order were issued pursuant to the survey completed on July 2, 2015.

The information presented with your letter, as well as in a face to face meeting with facility staff and MDH staff on September 24, 2015, the CMS and State 2567s dated July 2, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

State $Tag\ ID\ Prefix\ 0915-4658.0525\ Subp.\ 6A$: Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:

- A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to:
 - (1) bathe, dress, and groom;
 - (2) transfer and ambulate;
 - (3) use the toilet:
 - (4) eat; and
 - (5) use speech, language, or other functional communication systems; and

Refer to summary outlined in the MDH letter dated 11/17/15 addressing the IDR for federal deficiencies. The revised 2567 State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

Please note it is your responsibility to share the information contained in this letter and the results of

Woodlyn Heights Healthcare Center November 17, 2015 Page 2

this review with the President of your facility's Governing Body.

Sincerely,

Christine Campbell, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 218-302-6151

Fax: 218-723-2359

cc: Office of Ombudsman for Long-Term Care Pam Kerssen, Assistant Program Manager

Licensing and Certification File Susanne Reuss, Metro Team A District Office Unit Supervisor

PRINTED: 12/08/2015 FORM APPROVED

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 2 000 Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** Minnesota Department of Health is The facility has agreed to participate in the documenting the State Licensing electronic receipt of State licensure orders Correction Orders using federal software. consistent with the Minnesota Department of Tag numbers have been assigned to Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf Minnesota state statutes/rules for Nursing obul.htm The State licensing orders are Homes. delineated on the attached Minnesota

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 07/24/15

Electronically Signed

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING 07/02/2015 00829 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 2 000 Continued From page 1 Department of Health orders being submitted The assigned tag number appears in the far left column entitled "ID Prefix Tag." electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter The state statute/rule number and the the word "corrected" in the box available for text. corresponding text of the state statute/rule Then indicate in the electronic State licensure out of compliance is listed in the "Summary Statement of Deficiencies" process, under the heading completion date, the column and replaces the "To Comply" date your orders will be corrected prior to portion of the correction order. This electronically submitting to the Minnesota column also includes the findings which Department of Health. are in violation of the state statute after the statement, "This Rule is not met as A complaint investigation was conducted to investigate complaint #H5320042. The complaint evidenced by." Following the surveyors findings are the Suggested Method of was not substantiated. Correction and the Time Period For Correction. 11/16/15 Revised MDH licensing orders as a result of an Informal Dispute Resolution. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. 8/11/15 2 570 MN Rule 4658.0405 Subp. 4 Comprehensive 2 570 Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ B. WING _ 07/02/2015 00829 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 570 2 570 Continued From page 2 quardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: No POC required. Based on document review and interview, the facility failed to review and revise the care plan for 1 of 1 residents (R43) for ambulation and positioning and failed to revise the care plan for 1 of 1 resident (R69) for refusing weights. Findings include: R43's care plan was not updated to reflect a change for restorative nursing ambulation. R43's care plan dated, 2/18/15, directed staff for mobility "Limited physical mobility r/t (related to) right humeral arm fracture, advanced age, fall history and history of vertigo. Ambulation: Requires 2 staff assistance for mobility" R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent on staff for activities of daily living (ADL's). R43 was discharged from physical therapy 4/10/15, with a notation on a form titled, Therapist Progress and Discharge Summary, to "ambulate 15 feet with L hall railing on even surfaces with care giver assistance. The long term goal read; ambulate x 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living facility) or SNF (skilled nursing facility)." Furthermore, the discharge summary read,

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 00829 07/02/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) 2 570 2 570 Continued From page 3 "Training provided to some of the nursing staff." R43's plan of care also directed staff; "[R43] has potential for impairment to skin integrity and pressure ulcer development with actual pressure ulcer at this time r/t (related to) advanced age. fragile skin, incontinence, functional decline. oxygen dependency, edema, and requiring assistance with bed mobility, transfers, hygiene, and ambulation." The Intervention read, "Encourage reposition/position changes during Customer Service Rounds." There were no other directions related to positioning in the wheel chair on the plan of care, however, the treatment sheet directed staff to "Reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift. Start date 4/2/15." During an observation on 6/29/15, at 4:45 p.m., R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m. During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 570 2 570 | Continued From page 4 and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time. NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour. R69's plan of care was not updated to include R69's refusal of care.

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 570 2 570 Continued From page 5 Review of R69's medical record indicated a physician order for "daily am (morning) weights. Record in point click. Notify MD for wgt (weight) gain 3 lbs/24 hrs (3 pounds in 24 hours) 5 lbs/week or wgt exceeding 10 lbs from admission weight (414.4 lbs)." Review of the medication administration record (MAR) indicated R 69 refused to be weighed every day in June. Review of R69's May 2015 MAR indicated the resident refused to be weighed all but two days. Review of R69's physician order record indicated a physician order for the following "CPAP Icontinuous positive airway pressure (used to keep airways open, used by people who have breathing problems, such as sleep apnea)] on HS [hour of sleep] off AM: Heated humidifier, full facemask (not nasal mask) head gear, filters and tubing. Pressure 8 cm of H2O [water]. Length of need: Indefinite. Must wear nightly" Review of R69's June MAR indicated R69 refused the CPAP every day in June. When interviewed on 7/2/15, at 10:27 a.m. licensed practical nurse (LPN)-C stated R69 refused to get out of bed daily, refused daily weights, and refused to wear the CPAP at night. LPN-C verified R69's refusal of care was not on the plan of care, and should have been. Suggested Method of Correction: The DON or desigee could work with the interdisciplinary team, MDS coordinator and nurse managers to review the assessments for accuracy, create comprehensive care plans, review and revise the procuedure for care plan updating, and then

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could educate staff. The DON or designee could

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 570 2 570 Continued From page 6 also perform audits of resident records to determine if the care plans were based on comprehensive assessment, updated in a timely fashion and then accessible for staff. Time Period for Correction: Twenty-one (21) days. 2 830 8/11/15 2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced Based on record review and interview, the facility No POC required. failed to thoroughly document a nursing assessment after 1 of 1 resident (R55) complained of not feeling well and expired unexpectedly the following day. Findings include:

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Review of Progress Notes revealed that R55 was admitted to the facility 4/14/15, with admitting diagnoses that included chronic airway

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(X3) DATE SURVEY COMPLETED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: ____

00829

B. WING _ 07/02/2015

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**

	INVER GROVE HEIGHTS, MN 55077							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
2 830	Continued From page 8	2 830						
	provided to residents and report the findings to the quality assurance committee.							
	TIME PERIOD FOR CORRECTION: Thirty (21) days.							
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required	2 885		8/11/15				
	Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities.							
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an ambulation program to improve or maintain a resident's ability to ambulate for 1 of 1 resident (R43) reviewed for ambulation. Findings include:							
	R43 had been admitted from an assisted living facility on 2/6/15,following a fall and fracture of the right humerus (upper arm). According to interagency transfer documentation at the time of admission, R43 had been ambulating 300 feet at the assisted living, according to the therapy goals.							
	A fourteen day minimum data set (MDS)							
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6/29/15. R43 was not offered assistance or

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 885 2 885 Continued From page 10 encouragement to stand or walk. At 5:15 p.m., R43 was seated at the dining room table wearing gripper socks, with no foot pedals on the wheel chair. During an observation 7/1/15 from 7:00 a.m. until 7:30 a.m., R43 was seated in a wheel chair by a table near the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m., R43 was wheeled back to her bedroom. At 8:40 a.m. R43 was observed during a transfer. R43 was only able to tolerate standing for 30 seconds before stating, "that's enough!" R43 was then assisted to transfer to her bed with the assistance of one staff, nursing assistant (NA)-A. During the observation, NA-A verified at 8:40 a.m. that R43 had been transferred into the wheelchair at 6:30 a.m. without an encouragement/assistance to ambulate. NA-A stated R43 was not physically able to take any steps. NA-A stated she herself worked full time on the unit, but had not walked or attempted to walk R43 since admission/re-admission. Family member (F)-A was present during the transfer 7/1/15, at 8:40 a.m., and acknowledged that staff did not ambulate R43. F-A stated, "They stopped walking her." F-A further stated R43 had been independent in the assisted living prior to the fractured right arm, and said she was afraid R43 would lose her ability to walk. During this conversation, R43 expressed a desire to be walked in hopes of returning to the assisted living. During an interview on 7/2/14, at 11:00 a.m., with NA-B, another full time staff, she stated she did not realize R43 was supposed to ambulate. During an interview with licensed practical nurse

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 885 Continued From page 11 2 885 (LPN)-A on 7/2/15 at 11:30 a.m., she verified she was aware R43 could take steps, but did not know there was an ambulation program for R43. At that time, registered nurse (RN)-C was interviewed. RN-C stated she was the person who completed the MDS assessments. She stated R43 had been admitted as extensive assist of 2 staff for walking in the room, and verified R43 had walked in the hallway five of the seven observation days during an assessment review period (ARD) of 2/17/15. Additional record review revealed R43 had been discharged to the hospital for surgical repair of the humerus fracture on 3/12/15. Upon return from the hospital, the 5 day MDS dated 3/22/15, the 14 day MDS dated 3/29/15, and the 30 day MDS dated 4/12/15, all indicated there had been no ambulation in the bedroom or hallway during the observation periods. Document review of R43's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R43 as cognitively intact with dependence on staff for activities of daily living (ADL). The nursing assistant care sheet dated 7/1/15, indicated: "non ambulatory for in room and hallway." When interviewed on 7/2/15, at 1:12 p.m., the physical therapy assistant (PTA) thought it was possible the nursing referral sheet had not been completed and passed on to the nurse. The PTA expressed training two nursing assistants to ambulate R43 using the left arm and the handrail in the hallway. When interviewed on 7/2/15, at 1:20 p.m., RN-A expressed not knowing R43 could walk and

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 885 2 885 Continued From page 12 acknowledged the process had been "dropped" because nursing had not received the rehab referral from the therapy department. Additional information was submitted by the executive director of the facility, after survey, July 7, 2015: "R43's ability to ambulate had been inconsistent since her admission due to instability secondary to right humeral fracture, then due to surgical repair of the humeral fracture with restrictions of the RUE [right upper extremity] and then with a significant laceration to her LLE [left lower extremity] with edema." "Point of Care Documentation shows that R43 has never ambulated in the hallway since her admission. She has been inconsistent but does ambulate in her room with extensive assistance of one staff. She maintains her ability to participate consistently in her bed mobility. Upon discharge from physical therapy 4/10/2015 R43 did not achieve her goal of ambulation 50 feet with staff assistance but was ambulating a distance of 15 feet with contact guard assistance." "Resident R43 was referred to therapies on 7/7/2015 for gait training and to initiate a gait program. On 7/7/2015 Resident (R43) current level of function is noted that she ambulates 15 feet on even surfaces with minimal assist using left handrail and right upper extremity supported on therapies arm. Resident's current level of function demonstrates that she continues to improve and did not have a loss of ability. A walking program has been put in place. R43 is currently receiving pain medication to promote mobility".

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED			
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2 885	Continued From pa	age 13		2 885			
	The Director of Nurcould develop, reviprocedures to ensuprovided. The Director of Nurcould educate all a and procedures. The	R CORRECTION:	nee ies and ing is nee policies Services				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pre	essure	2 900			8/11/15
	comprehensive res	e sores. Based on the sident assessment, the must coordinate the nursing care plan which					
	without pressure s pressure sores unl condition demonst	no enters the nursing heores does not develop less the individual's cli rates, and a physician they were unavoidable	nical				
	receives necessar	who has pressure sore ry treatment and service prevent infection, and peveloping.	es to				
	by:	nent is not met as evid			No POC required.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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2 900	Continued From pa	age 14	2 900					
	assessed to be at r	f 1 resident (R43) who was risk for developing pressure ed a pressure ulcer after						
	Findings include:							
		2/6/15, from an assisted living						
	humerus (upper ar	n-repaired fracture of the right m,) with instructions to wear a rm with limited mobility.						
	Data Set (MDS) da was cognitively into activities of daily liv indentified R43 wa pressure ulcers. The	of R43's admission Minimum ated 2/13/15, indicated R43 act and was dependent with ving (ADL's). The MDS is at risk for the development of here were no unstageable skin sure ulcers identified.						
	an unstageable pro 8:35 a.m. and read morning by the atte assistant/registere [R43's] right glutea measures 1.5 cm (Medial) measures (Posterior) measures (Posterior) measure applied to Superior applied to medial a unstageable, dark #2 and #3 beefy re pain with dressing get official treatme							
	notes was made o	ocumentation in the progress on 3/4/15, at 7:40 p.m., and outtock presents with three						

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING_ 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 2 900 Continued From page 15 open areas. The most superior is unstagable, covered with thick, firm cap of slough. It is surrounded by beefy redness. Peri wound is blancheable. Medial buttock with are of [sic] shearing. Allevyn Gentle Border dressing (small) placed atop superior wound. 4 Layers of skin prep applied to medial and inferior areas to protect skin. [R43] denies discomfort with any of the areas palpated or treatment performed. Will ask am staff tomorrow to call for orders for the Allevyn and Skin prep orders." The form titled Medication Administration Record (MAR) dated 3/1/15-3/31/15, begins to sign out Allevyn Gentle Border to (R) buttock (Superior wound) change every 3 days and prn (whenever necessary) on 3/4/15. The next direction on the medication sheet is for 4 layers skin prep to medial and inferior areas of shearing (R) buttock. Apply every shift. This is first signed out on the MAR on 3/4/15, 3-11 shift. R43 was seen at the wound clinic on 4/2/15 at 9:42 a.m. and the physician note read, "[R43] is being seen at the Vascular Clinic today regarding coccyx wound." The epidermal and dermal tissues were sharply debrided for a total square cm (centimeter) of 10. Devitalized and non viable tissue was removed to improve granulation tissue formation, stimulate wound healing, decrease overall bacteria load, disrupt biofilm formation and decrease edge senscence." Review of R43's, Order Summary Report, dated 4/2/15, identified a physician order, "reposition every 2 hours when in bed and every 30 minutes when up in wheelchair every shift." The form titled, Treatment Record, for June 2015

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R43 was seated at the dining room table. R43 was wearing gripper socks, and there were no foot pedals on the wheel chair. R43 was not offered to stand or change position from the staff during the observation period from 4:45 p.m. until 6:00 p.m.

During an observation from 7/1/15 from 7:00 a.m. until 7:30 a.m. R43 was seated in a wheel chair at a table by the elevator. At 7:30 a.m. R43 was wheeled to the dining room for breakfast. At 8:30 a.m. R43 was wheeled to the bedroom. At 8:40 a.m. R43, with 1 staff assistance, was transferred to bed. When interviewed on 7/1/15, at 8:40 a.m., nursing assistant (NA)-A, verified R43 was up at 6:30 a.m. into the wheelchair and there were no offers to change position or offload buttocks, during this two hour and ten minute period of time, NA-A, acknowledged the aide assignment sheet did not specify half hour position changes and stated NA-A worked full time and had never been informed that R43 required a position change every 30 minutes. Furthermore, NA-A validated R43 was not able to physically change position while seated. Observation of R43s' skin when settled into bed at 8:45 a.m., revealed red creases and crevices to posterior thighs and buttocks area from the brief. NA-A verified the numerous red creases and crevices were present to posterior thighs and buttocks. R43 was not

If continuation sheet 18 of 42

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER** INVER GROVE HEIGHTS, MN 55077 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 2 900 Continued From page 17 incontinent of urine at this time. LPN-A proceeded with the dressing change to the superior right buttock. Review of wound measurements from 6/30/15 and documentation from the Skin/Wound note which read; "1.6 x 1 x 0.2 cm (centmeter) 100% granulation tissue. No tunneling noted with gentle probing of wound bed. Cleansed. Patted Dry. 2 x 2 gauze pad cut in half and moistened with acetic acid. Placed in wound bed. Covered with ABD pad and secured with hypafix tape." The largest measurements for the right superior area were recorded in the progress notes 3/15/15, as 4.3 x 2.5 cm. (centimeter) Depth is =/> [sic] 2.6 cm. Documentation in the progress notes indicated the right medial and right inferior buttock wounds healed 3/18/15. The superior decubitus was measured on 6/30/15, as 1.6 length x 1.0 width x .20 depth in centimeters. The facility transitional care physician documented a visit to R43 on the form titled, Healtheast Medical Care for Seniors dated 3/2/15, however, there was no mention of any buttock wound issues. Furthermore the physician documented visits to R43 on 3/6/15, 3/9/15, 3/16/15, 3/20/15, 3/23/15 and did not address any buttock wound issues. On 3/27/15, the physician wrote. "Breakdown of skin involving buttock region. Nursing staff request referral to wound clinic which is made. Additionally, load-off cushion to the chair and air mattress are to be obtained." During an interview with the director of nursing (DON), registered nurse (RN)-A and RN-C on

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7/2/15, at 10:00 a.m., there was no data or information available indicating specific skin

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 2 900 Continued From page 18 inspections associated with bathday prior to the unstageable wound discovery 3/1/15, because the facility documented in the computerized progress notes a statement which read, "bruises" associated with the admission right arm fracture, and if there was no skin issue, there would be no other documentation. The undated facility policy, titled, Comprehensive Skin and Positioning Evaluation UDA (User Defined Assessment) was not used for R43 because the facility did not use the form until there were wounds, according to the DON. Interview on 7/2/14, at 11:00 a.m., with NA-B, who worked full time, also verified not being aware R43 was to have a position change every 30 minutes, while seated, and validated the aide assignment sheet did not inform staff to change R43's position every half hour. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate nursing staff regarding providing nursing care and supervision for residents according to the resident's individual needs and assessment. The DON or designee could monitor the care provided to residents and report the findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Thirty (21) days. 8/11/15 21426 MN St. Statute 144A.04 Subd. 3 Tuberculosis 21426 Prevention And Control

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(a) A nursing home provider must establish and

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21426 21426 Continued From page 19 maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced No POC required. Based on document review and interview, the facility did not provide tuberculosis screening for 4 of 5 employees (E-A, E-B, E-C, E-E) and 2 of 5 residents (R47, F115) reviewed for tuberculosis screening. Findings include: Employee record review revealed employee (E)-A, hired 5/18/15, did not have a completed symptom screening and had only one step of tuberculin skin testing documented on 5/16/14. E-B, hired 4/7/15, had only one step of tuberculin skin testing documented on 4/4/15.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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21426	E-C, hired 2/19/15, dated 1/19/04, that Impression: Negat documentation of a examination with the E-E, hired 4/7/15, he 11/08/11, that read MantouxFINDING disease There corresponding physichest x-ray. Review of R47's readmitted on 6/15/1 in the record for testing to the tuberculosis infection admission in 2011. R115's record shown and the only document testing for presence a one-step tuberculosis in the facility's tuberculosis. Baseline Testime of hire for all I Minnesota. Baseline assessing for curredisease, (2) assess for the presence of tuberculosis by addituberculin skin testings licensed and the only document of the presence of tuberculosis by addituberculin skin testings licensed and the only document of the presence of tuberculosis by addituberculin skin testings licensed and the only document of the presence of tuberculosis by addituberculin skin testings licensed and the only document of the presence of tuberculosis by addituberculin skin testings licensed and the only document of the presence of tuberculosis by addituberculin skin testings licensed and the only document of the presence of tuberculosis by addituberculin skin testings licensed and tuberculin skin testings lic	had a chest x-ray report, read, "Indication: +PPD. ive chest." There was no a corresponding physical ne chest x-ray. had a chest x-ray report, dated, "INDICATION: Positive GS:Lungs are clear of active was no documentation of a sical examination with the ecord showed the resident was 3 and the only documentation sting for presence of on was from a previous wed she was admitted 4/4/15 mentation in the record for se of tuberculosis infection was alin skin test dated 1/4/15. culosis policy, dated 4/2/15, a screening is required at the health care workers in ne TB screening includes: (1) ent symptoms of active TB sing TB history, and (3) testing f infection with Mycobacterium ministering either a two-step t (TST) or single TB blood screening of patients is admission for health care as boarding care homes and aseline TB screening includes: or single TB blood test, (2) TB and (3) assessment of the				

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21426	Continued From pa	ige 21	21426				
	surveyor requested from the director of she would look for 7/7/15, at 2:10 p.m that she could not l	on 7/2/15, at 9:30 a.m. the I the missing documentation nursing and she stated that it. During a phone interview on the director of nursing stated ocate any more his point, but would keep					
:	The director of nurdevelop, review, an Control/tuberculosi	THOD OF CORRECTION: sing (DON) or designee could nd/or revise Infection s program and ensure that uberculosis prevention are lyzed.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21530	MN Rule 4658.131	0 A.B.C Drug Regimen Review	21530			8/11/15	
	reviewed at least no currently licensed. This review must be Appendix N of the Surveyor Procedur Requirements in Least the Department of Health Care Finan This standard is in available through the system. It is not seen to currently like the system. It is not seen the surveyor the system of the system. It is not seen the system of the system.	nen of each resident must be nonthly by a pharmacist by the Board of Pharmacy. De done in accordance with State Operations Manual, res for Pharmaceutical Service ong-Term Care, published by Health and Human Services, cing Administration, April 1992. Incorporated by reference. It is the Minitex interlibrary loan subject to frequent change. The accist must report any edirector of nursing services.					

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Findings include:

reviewed for unnecessary medications.

Record review revealed a 5/12/15, physician's order for clonazepam (anti-anxiety medication) 1 milligram (mg) by mouth at bedtime for paranoid

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2060 UPPER 55TH STREET EAST

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21530	Continued From page 23	21530		
	schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed R1 was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1-(Clonazepam) agitation" There were no details of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident.			
	When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused care, could be delusional, and could not stop talking.			
	The Record of Medication Regimen Review form dated 5/19 and 6/18/15, revealed the consulting pharmacist had reviewed R1's drug regimen. However, there were no notes or recommendations found in the record regarding the lack of specific target behavior of agitation for this resident.			
	During a telephone interview on 7/2/15, at 2:25 p.m. the facility's consulting pharmacist was asked if she looked for specific target behaviors with the use of psychoactive medications when reviewing resident records. The consulting pharmacist replied that she did look for the specific target behaviors and made recommendations to use specific target behaviors. The surveyor mentioned there was a Consultant Pharmacist Communication to Nursing for this resident on 2/21/15, which included the recommendation to use "patient specific Target Behaviors" for the use of several other psychoactive medications that R1 was			

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 07/02/2015 00829 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21530 Continued From page 24 21530 explained she had spoken with the staff at the facility about this requirement and the nurse consultants for the facility stated were working on improving the documentation of appropriate target behaviors at this facility. SUGGESTED METHOD OF CORRECTION: The pharmacist and/or director of nursing could in-service and monitor for compliance with maintaining a functional and safe pharmaceuticals services for the residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days. 8/11/15 21535 MN Rule4658.1315 Subp.1 ABCD Unnecessary 21535 Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy: B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21535 Continued From page 25 21535 available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced No POC required. Based on record review and interview 2 of 10 residents (R1, R69) medications reviewed did not have monitoring of specific target behaviors related to the use of the anti-anxiety medication clonazepam for R1 and did not assure physician orders were followed for R69. Findings include: Record review revealed a 5/12/15, physician's order for clonazepam 1 milligram (mg) by mouth at bedtime for paranoid schizophrenia. The medication administration records for June, 2015 and July, 2015, revealed the resident was currently receiving this medication. The treatment administration records for June, 2015 and July, 2015 read, "Target Behavior #1- (Clonazepam) agitation..." There were no details of this behavior listed. There was no reference to a target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused cares, could be delusional, and can't stop talking.

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R69's medical record lacked documentation ensuring adequate monitoring of medications.

Review of R69's Medication Review Report dated

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SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written

under this licensing order.

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: _ B. WING 07/02/2015 00829 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21545 21545 Continued From page 28 prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: No POC required. Based on observation, interview and document review the facility did not ensure four expired medications were removed from storage for 2 of 4 medication carts reviewed, potentially affecting 3 residents (R8, R22, R40). Findings include: Review of the medication cart for the 600 hallway, on 6/29/15, at 12:35 p.m. the following were discovered: an open bottle of Levemir insulin for R8, with an opened on date of 5/12/15, (48 days prior); an open bottle of guaifenesin (cough medicine), 200 milligram (mg) tablets for R22, with an unreadable direction label, and an expiration date of 3/15. Registered nurse (RN)-B verified the medications were expired and should not be used, and the direction label on the bottle of guaifenesin was unreadable. Review of the medication cart for the 500 hallway, on 6/29/15, at 12:53 p.m., the following were discovered: an open bottle of Lantus insulin for R40, with an opened on date of 5/22/15. (38 days

prior.)
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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER** INVER GROVE HEIGHTS, MN 55077 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21545 21545 Continued From page 29 Licensed Practical Nurse (LPN) - E verified the date and indicated the insulin was expired and should not be used. Review of R8's record indicated a physician order for Levemir solution (Insulin Detemir) Inject 28 unit subcutaneously every evening shift for diabetes. Review of R22's record indicated a physician order for guaifenesin tablet 400 mg tablet oral cough when necessary (prn.) Review of R40's record indicated a physician order for Lantus Solution (Insulin Glargine) Inject 8 unit subcutaneously one time a day related to diabetes. The Medication Expiration Procedure dated March 2015, indicated insulin vials had an expiration date of 30 days after opening. The procedure also indicated medications would be discontinued at the date of expiration the medication. Suggested Method of Correction: The director of nursing (DON) or designee could conduct training for all staff responsible for administering medication to residents to ensure staff are following facility policies and procedures and ensure medication expirations are not occurring. The DON or designee could monitor to ensure medication expiration dates are not occurring. Time Period for Correction: Fourteen (14) days.

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that helps with this issue, and we have a new radio system in place to communicate more

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21870	effectively. 4. There weekends. Encourse well as fill out a feer nurses if this occur [evening/afternoon purchased should more recent meeting. The facility failed to call light wait time. A review of R77 and revealed R77 was extensive assistant toilet use and persected dependent on staff. On 7/1/15 at 3:15 persected minutes for to help move his less a window closed were ported he had specurrent and former light wait times. Or again confirmed he significant amount with getting his leg reported call light of with not enough do A review of call light revealed R77 wait assistance on the 6/21, morning of 6/23, morning of 6/23, morning of 6/23 time concerns for	e is a Manager on Duty on the aged to speak with them, as dback form. Talk with the s in the PM . New radio that were recently help as well." There were nongs for Family Townhall. of follow up on concerns related es for R77. Inual MDS, dated 5/15/15 cognitively intact and required be for bed mobility, dressing, onal hygiene and was totally for transfers. o.m. R77 reported he waited a assistance on a recent night ges back on the bed and to get then his room was cold. R77 toke with the administrator, of director of nursing about call and 7/2/15 at 10:05 a.m. R77 thad recently waited a of time in pain for assistance as back on the bed, R77 concerns were a chronic issue one to resolve the issue. Int log for 6/21/15 to 6/27/15 the dover a half hour for following instances: morning of 1/26 and morning of 6/27. To follow up on call light wait	21870			

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	ENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		• ,	CONSTRUCTION	COMPLETED		
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[I re ir ir n te con n fi con n te con n fi con n te con	equired staff assis including: extensive nobility, transfer, looilet use and persoquarterly MDS furth moderately cognitive requently incontine on 6/29/15 at 5:21 F)-B, reported staffights within a reasonad observed R9 veported "some aid to button calls." F-E orief because staffin a reasonable time oriefs. F-B reported problem may have with each other who staff may not have to alert them of call light times occurred on a daily visited R9 daily at vexceeded thirty min morning and afternevening on 6/15, a 6/17, morning of 6/24. The facility failed to times for R11. R11's most recent revealed he was considered and some considered and some considered are considered as a facility failed to the considered and some considered and some considered are considered as a facility failed to the considered and some considered and some considered are considered as a facility failed to the considered and some	5 further confirmed R9 tance to meet basic needs assistance required for bed ocomotion on unit, dressing, anal hygiene. R9's 5/5/15 her revealed she was rely impaired and was ent of urine and bowel. p.m. a family member of R9, if were not responding to call broable time. F-B reported she wait over an hour for help. F-B es don't care and don't come added R9 wore a disposable were not answering call lights are and R9 had waited in soiled a she believed part of the been staff not communicating en they went on breaks and worn the walkie system used I lights. F-B reported extended a reason of the pasis. F-B reported she	21870				

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when R115 was in the bathroom and sometimes

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 07/02/2015 00829 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21870 21870 Continued From page 36 waited 30 minutes for staff to help. Review of R115's call light record for 6/21 to 6/27/15 revealed the following wait times were over 30 minutes: the evenings of 6/21 and 6/22/15; and the afternoons of 6/22, 6/23 and 6/26/15. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkies. The facility had investigated call light wait times from the previous week after surveyor brought the concern to the facility's attention, but could not reach a conclusion. Any additional follow up information from the resident council concerns was requested and the administrator reported there was nothing further. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved. During an interview on 6/30/15, at 8:39 a.m. R64 who was cognitively intact, expressed frustration with attending resident council meetings because. while residents share how call lights are not being answered in a timely fashion the facility failed to adequately address the residents concern. R64 stated staff ignore the walkie talkies when they go off for a call light. R64 expressed personally seeing staff sleeping on the couches or playing cards at the table at 5:00 a.m. and turning off the call light beepers. R64 stated they had informed

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21870 21870 Continued From page 37 facility staff of these issues and knew call light issues had been discussed at several resident council meetings. R64 stated, "Going to the resident council meetings is a meet, eat, and retreat meeting, because things discussed do not change." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review or revise policies, provide education for staff regarding resident grievance process. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. Time Period for Correction: Twenty-one (21) days. 8/11/15 21880 21880 MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21880 21880 Continued From page 38 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed: specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced No POC required. Based on interview and document review, the facility failed to actively resolve personal grievances expressed for 2 of 2 residents (R9, R77) regarding call light wait times. Findings include: The facility failed to resolve a grievance regarding call light wait times, expressed by R9's family. On 6/29/15, at 5:21 p.m., a family member of R9, (F)-B, reported staff were not responding to call lights within a reasonable period of time. F-B reported they had observed R9 wait over an hour

Minnesota Department of Health

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST WOODLYN HEIGHTS HEALTHCARE CENTER **INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21880 21880 Continued From page 39 for help, and stated "some aides don't care and don't come to button calls." F-B added, R9 wore a disposable brief because staff were not answering call lights in a reasonable time and R9 had waited in soiled briefs. F-B reported she believed part of the problem may have been staff not communicating with each other when they went on breaks and staff may not have worn the walkie talk system used to alert them of call lights. F-B reported visiting R9 daily, at various times, and on various shifts and had observed extended call light times during visits. On 7/2/15, at 9:08 a.m., F-B reported she had expressed concerns about call light wait times at care conferences, had spoken with the administrator and other staff about call light concerns. F-B reported at one point, after waiting an hour and a half for R9 to get assistance she "went off on them and told them that was not acceptable." F-B added "they tell us to tell them when this happens, but nothing ever changes" and "they claim they have a system, but I said clearly it is not working." F-B reported these concerns were brought up about 2-3 months ago and a facility response was never received. A review of a Feedback Form dated 5/11/15, revealed F-B had expressed concerns about R9 waiting an unacceptable time for call light response. The facility noted they had educated the nursing assistants and were working on distributing more portable walkies to alert staff of call light alerts. However, there was no indication this measure had resolved the grievance, as there was no monitoring of the measure, as the facility was unable to provide documentation of monitorina. A review of call light times, for June 11 - 24, 2015

Minnesota Department of Health

revealed R9's call light times exceeded thirty

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 07/02/2015 00829 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21880 21880 Continued From page 40 minutes on the evening of 6/11/15; on the morning and afternoon of 6/13/15; on the afternoon and evening of 6/15/15; on the afternoon of 6/16 and 6/18/15; and on the mornings of 6/17, 6/18 and 6/24/15. R9's most recent quarterly Minimum Data Set [MDS] dated 5/5/15, revealed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15, quarterly MDS further revealed R9 was moderately cognitively impaired, and was frequently incontinent of urine and bowel. The facility failed to follow up on concerns related to call light wait times for R77. On 7/1/15, at 3:15 p.m. R77 reported waiting several minutes for assistance on a recent night for repositioning and to get a window closed, when his room was cold. R77 reported he had spoken with the administrator, current and former director of nursing about call light wait times. On 7/2/15, at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance with getting his legs back on the bed. R77 reported call light concerns were a chronic issue with not enough done to resolve the issue. Review of a feedback form, dated 5/11/15, revealed R77 had expressed concerns regarding call light wait times being longer than acceptable over a weekend. The facility noted they were distributing portable walkie talkies to staff. No further monitoring or follow up was documented.

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ B. WING 07/02/2015 00829 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST **WOODLYN HEIGHTS HEALTHCARE CENTER INVER GROVE HEIGHTS, MN 55077** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21880 21880 Continued From page 41 A review of the call light log dated 6/21 to 6/27/15, revealed R77 waited over half an hour for assistance on the following dates: the mornings of 6/21,6/22, 6/26 and 6/27; and twice on the mornings of 6/22 and 6/23/15. A review of R77's annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, and was totally dependent on staff for transfers. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkie talkies. The facility had investigated call light wait times from the previous week after surveyor brought the concerns to their attention, but could not reach a conclusion. On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved. SUGGESTED METHOD OF CORRECTION: The director of Social Services or designee could make sure resident grievances are listened to, acted upon and that results are reported back to the residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days.

Minnesota Department of Health STATE FORM

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 1RUJ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART	I - TO BE COMPLE	TED BY TH	E STAT	E SURVEY AGENCY	Faci	lity ID: 00829
MEDICARE/MEDICAID PROVIDER NO. (L1) 245320 2.STATE VENDOR OR MEDICAID NO. (L2) 679736900	3. NAME AND ADDRES (L3) WOODLYN HEIG (L4) 2060 UPPER 55TI (L5) INVER GROVE I	GHTS HEALT H STREET EA	HCARE AST	CENTER (L6) 55077	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIE		09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Comp	9. Other
6. DATE OF SURVEY 09/10//2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	03 SNF/NF/Distinct 0'	7 X-Ray	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DA	ATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 99 (L18) 13. Total Certified Beds 99 (L17)	10.THE FACILITY IS CE X A. In Compliance Wi Program Requirer Compliance Base 1. Accept B. Not in Compliance Requirements as	ith ments ed On: table POC	iivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A*	6. Scope of Services 7. Medical Director	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 99 (L37) (L38) (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE S	SHOW LTC CANCELLATIO	ON DATE):				
17. SURVEYOR SIGNATURE Jacob Mabera, HFE NE II	Date : 10/01	1/2015	7.10	18. STATE SURVEY AGENCY AP Kate Johns Ton, Pr		Date: 10/22/2015
PART II - TO	BE COMPLETED BY	Y HCFA REG	(L19) GIONAL	OFFICE OR SINGLE STAT		(L20)
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIA RIGHTS A	ANCE WITH CIV	TIL		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA-1.	513)
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 07/01/1986 (L24) (L41)	DATE E	TC AGREEMENT ENDING DATE L25)	Т	26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet	<u>RY</u> Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNATIV A. Suspension (L27) B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Sta 00-Active	tus Change
28. TERMINATION DATE: 29	. INTERMEDIARY/CARRI 03001	IER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539 32 (L32)	. DETERMINATION OF AP 08/07/2015	PPROVAL DATE	(L33)	Posted 10/27/2015 C DETERMINATION APPRO		



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245320 October 22, 2015

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

Dear Ms. Donahue:

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 October 1, 2015 the above facility is certified for or recommended for:

99 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 22, 2015

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

RE: Project Number S5320025

Dear Ms. Donahue:

On September 10, 2015, we informed you that the following enforcement remedies were being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 2, 2015, that included an investigation of complaint number H5320041, and lack of verification of substantial compliance with the health deficiencies at the time of our September 10, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 10, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 1, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a complaint investigation, completed on July 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 2, 2015, as of October 1, 2015.

Woodlyn Heights Healthcare Center October 22, 2015 Page 2

As a result of the PCR findings, this Department is also recommending to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of September 10, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 2, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 2, 2015, is to be rescinded.

In our letter of September 10, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johns Ton, Program Specialist Licensing and Certification Program

Health Regulation Division

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245320	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/10/2015
Name of Facility		Street Address, City, State, Zip Code	
WOODLYN HEIGHTS HEALTHCARE CEN	ΓER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5507	77

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).

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix Reg. # LSC	F0166 483.10(f)(2)		Correction Completed 08/11/2015		ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii),	(c)(2) -	Correction Completed 08/11/2015		ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 08/11/2015
ID Prefix Reg. # LSC	F0244 483.15(c)(6)		Correction Completed 08/11/2015		ID Prefix Reg. # LSC	F0253 483.15(h)(2)		Correction Completed 08/11/2015		-	F0280 483.20(d)(3), 483		Correction Completed 08/11/2015
ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 08/11/2015		ID Prefix Reg. # LSC	F0310 483.25(a)(1)		Correction Completed 08/11/2015		ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 08/11/2015
ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 08/11/2015		ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 08/11/2015			F0431 483.60(b), (d), (c		Correction Completed 08/11/2015
ID Prefix Reg. # LSC			-		ID Prefix Reg. # LSC								
Reviewed By		Reviewed I	Ву	Da	te:	Signature of	f Surve	yor:				Date:	
State Agency	1	SR	/KJ	10	/15/202	15		326	13			09/	10/2015
Reviewed By CMS RO		Reviewed I	Ву	Da	te:	Signature of	f Surve	yor:				Date:	
Followup to	Survey Compl 7/2/2						•				a Summary of to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 15, 2015

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

RE: Project Number S5320025

Dear Ms. Donahue:

On September 10, 2015, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 11, 2015. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 2, 2015, that included an investigation of complaint number H5320041, and lack of verification of substantial compliance with the health deficiencies at the time of our September 10, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 10, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 1, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a complaint investigation, completed on July 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 2, 2015, as of October 1, 2015.

As a result of the PCR findings, this Department has taken the following action:

• State Monitoring effective August 11, 2015 is rescinded effective October 2, 2015. (42 CFR 488.422)

This Department is also recommending to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of September 10, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 2, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 2, 2015, is to be rescinded.

In our letter of September 10, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely.

Kate JohnsTon, Program Specialist

Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992

Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00829	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/1/2015
Name	of Facility		Street Address, City, State, Zip Code	
W	OODLYN HEIGHTS HEALTHCARE CENT	ER	2060 UPPER 55TH STREET EAST	

INVER GROVE HEIGHTS, MN 55077

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
		Correction			Correction				Correction
10.0.5		Completed	15.5.6		Completed	15.5			Completed
ID Prefix		10/01/2015			-		Prefix		
-	MN St. Statute 144.651 Sub	d. 1	Reg. #			R	eg. #		
LSC			LSC				LSC		
		Correction			Correction				Correction
		Completed			Completed		_		Completed
ID Prefix			ID Prefix		-	ID F	Prefix		
Reg. #			Reg. #			R	eg. #		
LSC			LSC				LSC		
		Correction			Correction				Correction
15 5 °		Completed	15.5.6		Completed	15.5			Completed
ID Prefix			ID Prefix			IDF	Prefix		_
Reg. #			Reg. #				eg. #		
LSC			LSC				LSC		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix						ID F	Prefix		
Reg. #			Reg. #				eg. #		
LSC			LSC				LSC		
		Correction			Correction				Correction
		Completed			Completed		_		Completed
ID Prefix			ID Prefix		-	ID F	Prefix		
Reg. #			Reg. #			R	eg. #		
LSC			LSC				LSC		
Reviewed By		-	Date:	Signature of Surve	yor:	_		Date:	·
State Agency	S	G/KJ	10/22/2015		3545	6		1	0/01/2015
Reviewed By	Reviewed B	у	Date:	Signature of Surve	yor:			Date:	
MS RO									
ollowup to	Survey Completed on:						Was a Summar		
	8/11/2015			Uncorrecte	d Deficiencie	s (CMS-2567)	Sent to the Faci	ility? YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00829	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/10/2015	
Name	of Facility		Street Address, City, State, Zip Code		
W	OODLYN HEIGHTS HEALTHCARE CENT	ER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5507		

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y	4) Item		(Y5) D	ate
		C	Correction				Correction	on				Correction
ID Prefix	20570		Completed 08/11/2015		ID Prefix	20830	Complet 08/11/20		ID Prefix	20900		Completed 08/11/2015
			071172010				_				0525 S.Jbm	-
keg. # LSC	MN Rule 4658.040				keg. #	MN Rule 4658.0520 Subp.	_		LSC	MN Rule 4658.		.
												-
		C	Correction				Correction	on				Correction
		(Completed				Complet	ted				Completed
ID Prefix	20915	0	08/11/2015		ID Prefix	21426	_08/11/20	15	ID Prefix	21530		08/11/2015
•	MN Rule 4658.052		Α		0	MN St. Statute 144A.04 St			0	MN Rule 4658.		-
LSC					LSC		_		LSC			
		(Correction				Correction	on				Correction
			Completed				Complet					Completed
ID Prefix	21535		8/11/2015		ID Prefix	21545	_08/11/20		ID Prefix	21695		08/11/2015
Reg.#	MN Rule4658.1315	Subp.1 A	AB(•	MN Rule 4658.1320 A.B.C			Reg. #	MN Rule 4658.	1415 Subp.	4
LSC					LSC		_		LSC			
		(Correction				Correction	on				Correction
			Completed				Complet					Completed
ID Prefix	21870		8/11/2015		ID Prefix	21880	08/11/20		ID Prefix			
Reg.#	MN St. Statute 144	.651 Subo	d. 1		Reg.#	MN St. Statute 144.651 Su	ıbd. 2		Reg. #			
LSC					LSC				LSC			- ·
		(Correction				Correction	on				Correction
			Completed				Complet					Completed
ID Prefix					ID Prefix				ID Prefix			•
Reg.#					Reg.#				Reg. #			
LSC					LSC				LSC			
Reviewed By	Re	viewed By	/	Dat	e:	Signature of Surv	eyor:				Date:	
State Agency	,	SR	/KJ	10	/15/20	15		32613			09/1	0/2015
Reviewed By	Re	viewed By	/	Dat	e:	Signature of Surv	eyor:				Date:	
CMS RO												
Followup to	Survey Completed									a Summary of	•	
	7/2/2015	5				Uncorrect	ea Deticie	ncies (Ci	wi5-256/) Sent	to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 1RUJ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO	D BE COMPI	LETED BY T	HE STAT	E SURVEY AC	GENCY		Facility ID: 00829
MEDICARE/MEDICAID PROVIDER NO. (L1) 245320 2.STATE VENDOR OR MEDICAID NO. (L2) 679736900	(L3) V (L4) 2	WOODLYN HI 2060 UPPER 5	RESS OF FACILIT EIGHTS HEAL 5TH STREET I E HEIGHTS, M	THCARE EAST		55077	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PR 01 Ho		LIER CATEGORY	09 ESRD	<u>02</u> (L7	22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
6. DATE OF SURVEY 07/02/2015 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(- /	F/NF/Dual F/NF/Distinct F	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN	IG DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 99 13.Total Certified Beds 99	(L18)	A. In Compliance Program Requ Compliance B1. Acc	irements		2. Tec 3. 241 4. 7-D	hnical Personnel	Following Requirements:	ector
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY M	MEETS		
18 SNF 18/19 SNF 99	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARKS (IF APPI	(L39) LICABLE SHOW L	(L42) TC CANCELLA	(L43) TION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY API	PROVAL	Date:
Mary Beth Lacina, HFE	NE II	07	7/30/2015	(L19)	Kate JohnsTon, Program Specialist 08/06/2015 (L20			
PART	II - TO BE CO	OMPLETED	BY HCFA RE	EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY	(L21)	20. COMPI RIGHT	LIANCE WITH C S ACT:	IVIL	2.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HC	FA-1513)
22. ORIGINAL DATE 23. LTC	AGREEMENT	24.	LTC AGREEME	NT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION BE 07/01/1986	GINNING DATE		ENDING DATE	Ξ	VOLUNTARY 01-Merger, Clos		05-Fail to	Meet Health/Safety
(L24)	1)		(L25)			on W/ Reimbursemer untary Termination	nt 06-Fail to	Meet Agreement
	ERNATIVE SANC Suspension of Admis		(L44)		04-Other Reason		OTHER 07-Provid 00-Active	er Status Change
(L27) B. I	Rescind Suspension	Date:	(L45)					
28. TERMINATION DATE:	29. INTER	RMEDIARY/CAI	RRIER NO.		30. REMARKS			
(L28)		03001		(L31)				
31. RO RECEIPT OF CMS-1539	32. DETER	RMINATION OF	APPROVAL DAT	ΓE	Posted 08	3/07/2015 Co.		
(L32)				(L33)	DETERMIN	ATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 2, 2015

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

RE: Project Number S5320025

Dear Ms. Donahue:

On July 2, 2015, 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 actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 2, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5320042 that was found to be unsubstantiated.

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;

Woodlyn Heights Healthcare Center July 16, 2015 Page 2

<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 August 11, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 11, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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

Woodlyn Heights Healthcare Center July 16, 2015 Page 4

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 October 2, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 2, 2016 (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.

Woodlyn Heights Healthcare Center July 16, 2015 Page 5

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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

PRINTED: 07/30/2015 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		(X3) DATE SURVEY COMPLETED	
		245320	B. WING _	07	//02/2015	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	rs .	F 00	0		
	as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. A complaint investig	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance. acceptable electronic POC, andur facility may be conducted to intial compliance with the en attained in accordance with agation was conducted to int #H5320042. The complaint				
F 166 SS=D	was not substantiat 483.10(f)(2) RIGHT RESOLVE GRIEVA A resident has the r facility to resolve gr	ed. TO PROMPT EFFORTS TO	F 16	6	8/11/15	
	by: Based on interview facility failed to acting grievances express R77) regarding call Findings include: The facility failed to call light wait times,	resolve a grievance regarding expressed by R9's family.		The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions		
_ABORATOR\	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE	

Electronically Signed

07/24/2015

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.

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

PRINTED: 07/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07/0	07/02/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	•		
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	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 166	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 1	of State and Federal law. the foregoing statement, that: a) With respect to R#9 an patterns of call light responsesses to determine can medication schedule, and preferences for reducing than and wait for assistance. b) All staff will receive responding to call lights in manner and turning off the entering the room to meet needs. c) All staff will be re-educated process for following up where the facility's interdiscip (IDT) will audit via resident observations and/or call light identified as excessive investigated. e) Results of these audits documented in the facility's assurance meeting and resident for 3 months.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) of State and Federal law. Without waiving the foregoing statement, the facility states that: a) With respect to R#9 and R#77, patterns of call light response times were assessed to determine care times, medication schedule, and activity preferences for reducing the need to call and wait for assistance. b) All staff will receive re-edcuation on responding to call lights in a timely manner and turning off the call light when entering the room to meet individual needs. c) All staff will be re-educated on the process for following up with concerns from resident/family council meetings. d) The facility's interdisciplinary team (IDT) will audit via resident interviews, observations and/or call logs. Any call light identified as excessive will be investigated. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by the IDT for 3 months. f) DNS/Designee is responsible for		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07/0	02/2015	
	PROVIDER OR SUPPLIER /N HEIGHTS HEALTH	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE	
F 166	there was no monit facility was unable monitoring. A review of call ligh revealed R9's call liminutes on the ever morning and aftern afternoon and ever afternoon of 6/16 a mornings of 6/17, 6 R9's most recent of [MDS] dated 5/5/15 assistance to meet extensive assistance transfer, locomotion and personal hygie further revealed R9 impaired, and was and bowel. The facility failed to to call light wait tim On 7/1/15, at 3:15 pseveral minutes for for repositioning and when his room was spoken with the addirector of nursing and the control of	oring of the measure, as the to provide documentation of the times, for June 11 - 24, 2015 ight times exceeded thirty ning of 6/11/15; on the con of 6/13/15; on the sing of 6/15/15; on the ning of 6/15/15; and on the si/18 and 6/24/15. Quarterly Minimum Data Set is, revealed R9 required staff basic needs including: the required for bed mobility, in on unit, dressing, toilet use the needs of the single properties of the single properties of the single properties of the single provided in the single p	F 16	6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245320	B. WING	 	07/	02/2015	
	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	-		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
Review of a feedbarevealed R77 had of call light wait times over a weekend. The distributing portable further monitoring of the call revealed R77 waite assistance on the form of 6/21,6/22, 6/26 at mornings of 6/22 at A review of R77's at revealed R77 was extensive assistant toilet use, personal dependent on staff On 7/2/15, at 9:02 the facility was not response times as desk. The facility had inversions issues by The facility had inversions to their at conclusion. On 7/2/15, at 10:00 [DON] and administregular review of call issue had been disnew walkie talkies and administrator in have closely monitored.	ack form, dated 5/11/15, expressed concerns regarding being longer than acceptable he facility noted they were walkie talkies to staff. No or follow up was documented. light log dated 6/21 to 6/27/15, ed over half an hour for ollowing dates: the mornings and 6/27; and twice on the nd 6/23/15. annual MDS, dated 5/15/15 cognitively intact and required be for bed mobility, dressing, hygiene, and was totally for transfers. a.m. the administrator reported regularly checking call light she could not print it out at her ad worked on call light vordering new walkie talkies. Testigated call light wait times week after surveyor brought the tention, but could not reach a could not reach a could not reach a could light wait times, but the cussed at staff meetings and had been ordered. The DON eported the facility should ored call lights until resolved.				8/11/15	
		F 2	29		0/11/13	
	PROVIDER OR SUPPLIER IN HEIGHTS HEALTH SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa Review of a feedba revealed R77 had of call light wait times over a weekend. Ti distributing portable further monitoring of A review of the call revealed R77 waite assistance on the fof 6/21,6/22, 6/26 a mornings of 6/22 a A review of R77's a revealed R77 was extensive assistant toilet use, personal dependent on staff On 7/2/15, at 9:02 the facility was not response times as desk. The facility had response issues by The facility had invent from the previous was concerns to their ac conclusion. On 7/2/15, at 10:00 [DON] and adminis regular review of ca issue had been dis new walkie talkies and administrator r have closely monite 483.13(c)(1)(ii)-(iii)	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Review of a feedback form, dated 5/11/15, revealed R77 had expressed concerns regarding call light wait times being longer than acceptable over a weekend. The facility noted they were distributing portable walkie talkies to staff. No further monitoring or follow up was documented. A review of the call light log dated 6/21 to 6/27/15, revealed R77 waited over half an hour for assistance on the following dates: the mornings of 6/21,6/22, 6/26 and 6/27; and twice on the mornings of 6/21 and 6/23/15. A review of R77's annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, and was totally dependent on staff for transfers. On 7/2/15, at 9:02 a.m. the administrator reported the facility was not regularly checking call light response times as she could not print it out at her desk. The facility had worked on call light response issues by ordering new walkie talkies. The facility had investigated call light wait times from the previous week after surveyor brought the concerns to their attention, but could not reach a	PROVIDER OR SUPPLIER **N HEIGHTS HEALTHCARE CENTER** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Review of a feedback form, dated 5/11/15, revealed R77 had expressed concerns regarding call light wait times being longer than acceptable over a weekend. 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On 7/2/15, at 10:00 a.m. the director of nursing [DON] and administrator reported there was no regular review of call light wait times, but the issue had been discussed at staff meetings and new walkie talkies had been ordered. The DON and administrator reported the facility should have closely monitored call lights until resolved. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) F 2	PROVIDER OR SUPPLIER TO HEIGHTS HEALTHCARE CENTER TO HEIGHTS HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Review of a feedback form, dated 5/11/15, revealed R77 had expressed concerns regarding call light wait times being longer than acceptable over a weekend. The facility noted they were distributing portable walkie talkies to staff. No further monitoring or follow up was documented. 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(c)(2) - (4) F 225	ROVIDER OR SUPPLIER Name	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245320	B. WING _		07.	/02/2015	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5507			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 225	been found guilty of mistreating resident had a finding entered registry concerning of residents or mist and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must entered involving mistreatm including injuries of misappropriation of immediately to the atto other officials in a through established State survey and control of the facility must have a state survey and control of the facility must have a state survey and control of the facility must have a state of all into the administrator representative and with State law (includent, and if the state of the facility must have a state of all into the administrator representative and with State law (includent, and if the state of the facility of the state of the facility	onviduals who have it abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; whedge it has of actions by a can employee, which would or service as a nurse aide or the State nurse aide registry ties. It is sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law if procedures (including to the ertification agency). In the evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 2:	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245320	B. WING		07/0	02/2015	
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	ICARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	This REQUIREME by: Based on docume facility failed to conthorough investigat unknown origin, and details of the injury agency (SA) for 1 of for allegations of all Findings include: A facility incident reat 11:00 a.m. R43 lunknown origin ide from w/c (wheel chrequired ED (emer Documentation ind had reported to the clearly identified the wound. The follow State Agency on 4/specified): "Nursing skin tear on the low Resident is unable occurred. Resident (emergency room) Internal investigation on 4/27/15 (no tim had submitted to the investigative finding tear on the outer as [Nursing assistant] assisting the resider resident wheelchaic complication with the state of the complication with the state of the complication with the complication with the state of the complication with the complication with the complication with the complication with the complication of the complication with the complication with the complication with the complication of the complication with the complication of the complication with the complex com	nt review and interview, the applete an accurate and tion related to an injury of d failed to report accurate to the designated State of 3 residents (R43), reviewed buse/neglect or mistreatment. Seport indicated that on 4/21/15 and sustained an injury of ntified as: "skin tear transfer air) to bed. Significant gash gency department) transfer." icated that although the facility a State agency, they had not be severity of the resident's ing had been reported to the 21/15 (no time of day grassistant reported finding a ver left leg of the resident. To identify how the injury that was sent into the ER for evaluation and treatment.	F 225	The preparation of the following placorrection for this deficiency does reconstitute and should not be interpras an admission nor an agreement facility of the truth of the facts allegenconclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exsolely because it is required by provof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#43, internal investigation revealed laceration like caused by the mechanism of the foon the wheelchair. b) Facility will complete and report accurate and thorough investigation agencies) within 5 working days of the incident. If alleged violation is verification agencies with state law (including the State survey and certification agencies) within 5 working days of the incident. If alleged violation is verification agencies or receive action will be completing accurate and thorough investigations of injuries of unknown origin. d) ED/DNS will review each incident ensure an accurate and thorough investigation is completed. This information will be documented in the facility's quality assurance meeting reviewed by IDT for 3 months.	not reted by the ed on ent of necuted visions waiving retates ely pot rest electrical enterties in the ed et taken.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DENTIFICATION NI IMPED:		E CONSTRUCTION		E SURVEY PLETED
		245320	B. WING			07/	02/2015
	PROVIDER OR SUPPLIER			20	REET ADDRESS, CITY, STATE, ZIP CODE 160 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	the day. Therapy swith therapy sessi and unable to give tear was acquired to be evaluated, a day with sutures of internal investigation resident may have mechanism on the skin tear and whe height of injury. Up investigation no all substantiated." Although the facili unknown origin as agency, review of documentation dadescribed the injul lower leg laceration (centimeter) y shall lateral leg that is gevident. Unsure of laceration, no falls wheelchair. The wayer suture closu placed, stitch type prolene. The lacerathe skin was very amount of tension approximate the winformation from the diagnosis as a 19.	lage 6 If worked with therapy earlier in staff denies any complications on. Resident remains confused any insight as to how the skin any insight as to how the facility same losing the skin tear. After on, it appears as though the equality as the electric leg on the release align with con completion of internal couse or neglect was It had reported the injury of a skin tear to the State the emergency room ted 4/21/15, identified and ry of unknown origin as; "left ons. Pt (patient) has a 10-11 cm aped laceration to left lower apping and has fat globals [sic] if what happen [sic] that caused as possibility a piece on the round was closed using one are: skin layer: 22 sutures artion was Y- shaped, deep, ion, and measured 19 cm total attion was difficult to repair since thin and there was a large artion. Every effort was made to wound edges." The discharge the ER identified the treated cm complex leg laceration. of R43's quarterly Minimum ated 5/8/15, identified R43 as	F 2	225	e) The ED/Designee is responsible completion	for	

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245320	B. WING _		07	//02/2015
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55	DDE	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	assistance with action During an interview 7/1/15, at 8:00 a.m. that occurred to R4 staff did not inform investigation as to respect to the expressed seeing a blood and fat on the transported by pararoom. F-A stated, "I on the floor." Further complained when the leg really itches, who pants leg was then huge "blow out" acc F-A, the emergency speculated that the in the wheel chair a pinching was relieved. When interviewed administrator acknow informed of the incitivated he had not stated he report, it assistant director of on 6/1/15. He verifically ing document conducted since and former DON had not investigation. There the resident who was witness statements	th dependence on staff for vities of daily living (ADL's). with family member (F)-A on , F-A discussed an incident 3 and expressed concern that F-A of the outcome of the now the incident occurred. F-A a large 7 inch plate size area of a floor before R43 was medics to the emergency t looked like a pile of afterbirth ermore, F-A explained R43 ne two aides stood her up, 'my lat is the matter with it?' The pulled up and revealed the cording to F-A. According to room physician had calf may have been pinched nd when the pressure of the led, the skin just "blew apart". On 7/2/15 at 8:25 a.m., the owledged having been verbally dent on 4/21/15, although een the incident report until scovered in the former director office after she'd left their administrator stated that upon had been signed by the four investigation d acknowledged that the at the other or investigation d acknowledged that the out followed through with the end been no statements from as cognitively intact, no , no environment review, and in training to prevent	F 2	25		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07	/02/2015	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 225	Vulnerable Adult Abincluded under sec Source/Unexplaine classified as an injuboth the following of Federal: a. The source/Unexplaine observed by any perinjury could not be about the injury is susported in a surpling injury is located in a surpling in the injury of the linjury is located in a surpling in the injury is located in the injury is located in a surpling injury is suspended injury injury is located in a surpling injury is located in a surpling injury is suspended injury is located in a surpling injury is suspended injury is suspended injury is suspended injury is located in a surpling injury is suspended injury is suspen	t Policy and Procedure titled, buse/Neglect Prevention, tion #9; "Injuries of Unknown d Injuries. An injury should be ary of unkown source" when onditions are met: arce of the injury was not erson or the source of the explained by the resident: and occation of the injury (e.g., the an area not generally ma) or the number of injuries articular point in time or the sover time.	F 2	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING) DATE SURVEY COMPLETED		
		245320	B. WING		7/02/2015
	PROVIDER OR SUPPLIER	CARE CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 1060 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	the reported allegar directed staff to con interviewing the foll Resident interviews Resident health sta Medication review.	tion or incident". The policy nsider investigating and owing: Interviews of staff, s, Environmental review, tus, Behavior review,	F 225		
F 226 SS=D	policies and proced mistreatment, negle and misappropriation	ETC POLICIES evelop and implement written	F 226		8/11/15
	facility failed to imp investigation related origin for 1 of 3 rest allegations of abuse. Findings include: The facility's current Vulnerable Adult Abuincluded under sect Source/Unexplained classified as an injuboth the following of Federal: a. The soun observed by any peringury could not be b. The injury is suspoff the injury or the line or the sound of the sound	nt review and interview, the lement their policies for d to an injury of unknown idents (R43), reviewed for e/neglect or mistreatment. It Policy and Procedure titled, buse/Neglect Prevention, tion #9; "Injuries of Unknown d Injuries. An injury should be ury of unkown source" when conditions are met: urce of the injury was not erson or the source of the explained by the resident: and oiciouys because of the extent ocation of the injury (e.g., the an area not generally		The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was execute solely because it is required by provision of State and Federal law. Without waivin the foregoing statement, the facility state that: a) With respect to R#43, internal investigation revealed laceration likely caused by the mechanism of the foot re on the wheelchair. b) Facility will complete and report accurate and thorough investigations in	ed is ing es

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07/0	2/2015	
	PROVIDER OR SUPPLIER	ICARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 226	vuylnerable to trau observed at one paincidence of injurie State: If a reporter vulnerable adult hanot reasonably exp. The policy further i Submitting the Rep. Reporting procedu alleged abuse/neglobserved, a mandamake an initial represcuring the reside of the situation, the report to the Admir Nursing. 2. Upon resuspected abuse, be interviewed, rethe direct supervisia assigned to non-resuspended pending protection of the redirect of Nursing immediately instituted the reported allegal directed staff to conterviewing the fold Resident interviews. Resident health staff Medication review. A facility incident reat 11:00 a.m. R43 unknown origin ide from w/c (wheel chemostrates)	ma) or the number of injuries articular point in time or the sover time. has reason to believe that the is sustained an injury which is plained." Included information for port, listed under Internal res; "1. During the shift that the lect or unexplained injury is first ated reporter will immediately port to their Supervisor, after ent's safety. Following a review a Supervisor will immediately histrator and the Director of eport to a Supervisor of the che employee in question will assigned duties, placed under on of a licensed nurse, sident related tasks or grinvestigation. This is for the sident 3. The Supervisor, or Administrator will the an internal investigation of tion or incident". The policy insider investigating and lowing: Interviews of staff, so, Environmental review, atus, Behavior review,	F 226	accordance with State law (including the State survey and certification agencies) within 5 working days of incident. If alleged violation is veriful appropriate corrective action will be c.) Staff will receive re-education or completing accurate and thorough investigations of injuries of unknown origin. d) ED/DNS will review each incide ensure an accurate and thorough investigation is completed. This information will be documented in facility's quality assurance meeting reviewed by IDT for 3 months. e) The ED/Designee is responsible completion	the fied e taken. n wn nt to the g and		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245320	B. WING		07	//02/2015
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 226	had reported to the accurately describe wound. The follow State Agency on a specified): "Nursing skin tear on the long Resident is unable occurred. Resider (emergency room Internal investigated). On 4/27/15 (no time had submitted to investigative finding tear on the outer as [Nursing assistant assisting the resident wheelchase complication with Resident denies where the day. Therapy with therapy session and unable to give tear was acquired to be evaluated, and aday with sutures content investigation on the skin tear and wheelch all investigation no a substantiated."	dicated that although the facility to State agency, they had not ped the severity of the resident's wing had been reported to the 4/21/15 (no time of daying assistant reported finding a ower left leg of the resident. The to identify how the injurying the was sent into the ER.) for evaluation and treatment.	F 2	226		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07.	/02/2015	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 226	documentation date described the injury significant; "left low has a 10-11 cm (ce to left lower lateral globals [sic] eviden that caused lacerat on the wheelchair. one layer suture cloplaced, stitch type; prolene. The lacerat under a lot of tensic length. The lacerati the skin was very thamount of tension. approximate the woinformation from the diagnosis as a 19 compositively intact with assistance with act. During an interview 7/1/15, at 8:00 a.m. that occurred to R4 staff did not inform investigation as to lexpressed seeing a blood and fat on the transported by pararoom. F-A stated, "lon the floor." Further complained when the greally itches, when the greatly	ed 4/21/15, identified and of unknown origin as more er leg lacerations. Pt (patient) entimeter) y shaped laceration leg that is gaping and has fat t. Unsure of what happen [sic] ion, no falls, possibility a piece The wound was closed using osure: skin layer: 22 sutures simple interrupted, suture: 3-0 ation was Y- shaped, deep, on, and measured 19 cm total on was difficult to repair since nin and there was a large Every effort was made to ound edges." The discharge e ER identified the treated em complex leg laceration. If R43's quarterly Minimum ted 5/8/15, identified R43 as the dependence on staff for ivities of daily living (ADL's). If with family member (F)-A on and expressed concern that F-A of the outcome of the now the incident occurred. F-A a large 7 inch plate size area of the floor before R43 was a medics to the emergency lit looked like a pile of afterbirth the more, F-A explained R43 he two aides stood her up, 'my nat is the matter with it?' The pulled up and revealed the cording to F-A. According to y room physician had	F 2	26			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07/02/2015	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 226	Continued From page 13 speculated that the calf may have been pinched in the wheel chair and when the pressure of the pinching was relieved, the skin just "blew apart".		F 220	5		
F 244 SS=E	administrator acknown informed of the incistated he had not so the file had been displayed of nursing's (DON) employ. The admir finding the report, it assistant director of on 6/1/15. He verifically document conducted since an former DON had not investigation. There the resident who was witness statements and no education a recurrence of the in 483.15(c)(6) LISTE GRIEVANCE/RECOMENT When a resident or must listen to the vigrievances and recand families concernoperational decision life in the facility. This REQUIREMENT by: Based on interview facility failed to follows:	N/ACT ON GROUP	F 24	The preparation of the following pl correction for this deficiency does a constitute and should not be interp	not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	02/2015
	PROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIP CODE D60 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 244	which had the pote reviewed; R77, R9 Findings include: Review of Resider Minutes, dated 4/2 "Long call light tim shipment of radios process of marking distributed to staff light wait times." Of Meeting Agenda a Business "Long ca "New shipment of addressed in nurse and education of sand date included situation and educ for resolution. Add 5/21." The minutes resident satisfaction progress. The Resand Minutes for 6/0 on call light wait time requiring continues 5/19/15 minutes. Family Townhall M "2. Nurses/aide reteamwork. They a they aren't on their Timely call light time al times. 4. Aid there an incentive Action Plan noted there to help, will call teamwork. Upcom	ential to impact 6 of 6 residents 9, R11, R52, R115 and R64. Int Council Meeting Agenda and R1/15, revealed in new business e" with an action plan "new was received, we are in the g them and getting them the resident Council and Minutes noted in Old all light time" with the action radios was received, will be and nurse's aide meetings, staff on spot audits." Resolution "Ongoing monitoring of the ation of staff. Continuing date ressed in meetings on 5/20 and as did not include comments on with call light wait time sident Council Meeting Agenda 23/15, did not include follow up mes, despite being noted as did action and monitoring on the linutes, dated 5/21/15, revealed lationship-seems to be no ren't responding to residents if wing or if it's not their job. 3. nes, long call light time during es hide on the weekend, is for them to not do so?" The "Customer Service rounds are continue to re-educate staff on ing staff training scheduled for a to work on this issue, again.	F 2	244	as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was ex solely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#77, R#9, R#1 R#52, R#115 & R#64 patterns of caresponse times were assessed to determine care times, medication schedule, and activity preferences reducing the need to call and wait fassistance. b) All staff will receive re-edcuation responding to call lights in a timely manner and turning off the call ligh entering the room to meet individual needs. c) All staff will be re-educated on the process for following up with conceins from resident/family council meeting the facility's interdisciplinary teal (IDT) will audit via resident interview observations and/or call logs. Any olight identified as excessive will be investigated. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed by IDT for 3 months.	ed on ent of necuted visions waiving vistates on the contract of the contract on the contract of the contract	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07/	02/2015
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077	-	
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F 244	that helps with this radio system in place effectively. 4. There weekends. Encoura well as fill out a fee nurses if this occurs [evening/afternoon] purchased should have recent meeting. The facility failed to to call light wait time. A review of R77 and revealed R77 was dextensive assistant toilet use and persodependent on staff. On 7/1/15 at 3:15 personal minutes for to help move his less a window closed which reported he had spicurrent and former light wait times. On again confirmed he significant amount with getting his legs reported call light countries with not enough do A review of call light revealed R77 waite assistance on the feed/21, morning of 6/21, morning of 6/21.	rounds are being done and issue, and we have a new ce to communicate more e is a Manager on Duty on the aged to speak with them, as dback form. Talk with the is in the PM. New radio that were recently nelp as well." There were no ags for Family Townhall. follow up on concerns related es for R77. mual MDS, dated 5/15/15 cognitively intact and required ce for bed mobility, dressing, anal hygiene and was totally	F 24	f) DNS/Designee is responsible completion.	for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245320	B. WING			07/0	02/2015
	PROVIDER OR SUPPLIER			206	EET ADDRESS, CITY, STATE, ZIP CODE O UPPER 55TH STREET EAST ER GROVE HEIGHTS, MN 55077		
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F 244	R9's most recent of [MDS], dated 5/5/1 required staff assis including: extensiv mobility, transfer, letoilet use and persquarterly MDS furtimoderately cognitifrequently inconting. On 6/29/15 at 5:21 (F)-B, reported stallights within a reashad observed R9 reported "some aid to button calls." F-I brief because staff in a reasonable timbriefs. F-B reported problem may have with each other which staff may not have to alert them of call call light times occoccurred on a daily visited R9 daily at a A review of call ligh June 24th 2015 revexceeded thirty mimorning and afternevening on 6/15, a 6/17, morning of 6/24.	p follow up on call light wait R9. quarterly Minimum Data Set 5 further confirmed R9 stance to meet basic needs e assistance required for bed ocomotion on unit, dressing, onal hygiene. R9's 5/5/15 her revealed she was vely impaired and was ent of urine and bowel. p.m. a family member of R9, ff were not responding to call onable time. F-B reported she wait over an hour for help. F-B des don't care and don't come B added R9 wore a disposable were not answering call lights he and R9 had waited in soiled d she believed part of the been staff not communicating ten they went on breaks and worn the walkie system used I lights. F-B reported extended urred on various shifts and had a basis. F-B reported she	F2	244			

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-	PROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
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F 244	times for R11. R11's most recent revealed he was concent extensive assistant on 6/29/15 at 6:08 waited over an hout transferring and for incontinence cares "disgusted." R11's call light reconstruction of 6/24/1 afternoon of 6/24/1 afternoon of 6/24/1 afternoon of 6/27/1 The facility failed to time concerns for FR52's most recent she was cognitively assistance with toil on 6/29/15 at 3:34 see I shouldn't go to can't wait I have a how long she waite responded "someti Review of R52's ca 6/27/15, revealed to 1/21/15 and the afternoon of R115's revealed 4/21/15, rev	annual MDS, dated 5/23/15, ognitively intact and required ce for toileting and transferring. p.m. R11 reported he has ar for assistance with rassistance with toileting and ransferring. R11 noted he was ord for 6/21/15 to 6/27/15 was red over 30 minutes on the rest the morning of 6/21/15, the 5 and the morning and the 5. or follow up on call light wait R52. MDS, dated 4/10/15, revealed of intact. R52 required extensive reting and transferring. p.m., R52 reported "well you to the bathroom by myself, but I little bladder" and when asked and with her call light on, R52 mes it seems like forever." all light record for 6/21 to the following instances of call minutes: the morning of	F 2	244			

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	PROVIDER OR SUPPLIER			2060	ET ADDRESS, CITY, STATE, ZIP CODE UPPER 55TH STREET EAST ER GROVE HEIGHTS, MN 55077		
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F 244	on 6/30/15, at 10: R115, (F)-C, report when R115 was in waited 30 minutes. Review of R115's 6/27/15 revealed to over 30 minutes: t6/22/15; and the afolity and the facility was not response times as desk. The facility had investig the previous week concern to the fact reach a conclusion information from the was requested and there was nothing. On 7/2/15, at 10:0 [DON] and administregular review of cissue had been disnew walkie talkies and administrator have closely monit.	I mobility, transfers, dressing, sonal hygiene. 37 a.m. a family member of ted she had put her call light on the bathroom and sometimes for staff to help. call light record for 6/21 to he following wait times were he evenings of 6/21 and fternoons of 6/22, 6/23 and a.m. the administrator reported tregularly checking call light she could not print it out at her had worked on call light by ordering new walkies. The gated call light wait times from after surveyor brought the lility's attention, but could not h. Any additional follow up the resident council concerns defined the solution of the administrator reported.	F 2	244			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
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F 253 SS=D	adequately address stated staff ignore go off for a call light seeing staff sleepin cards at the table a call light beepers. Facility staff of these issues had been discouncil meetings. I resident council meretreat meeting, bechange." 483.15(h)(2) HOUS MAINTENANCE SE	y fashion the facility failed to the residents concern. R64 the walkie talkies when they are R64 expressed personally gon the couches or playing at 5:00 a.m. and turning off the R64 stated they had informed a issues and knew call light scussed at several resident R64 stated, "Going to the retings is a meet, eat, and cause things discussed do not sekkeeping &	F 244		8/11/15
	by: Based on observatoreview, the facility for was free of odors a condition for 2 of 2 for room odors. Findings include: When interviewed of stated an odor was really smells ripe in urine odor was noted. On 7/2/15, at 11:05	ion, interview and document ailed to ensure the bathroom and kept in a cleanable residents (R65, R51) reviewed on 6/30/15, at 10:46 a.m. R65 noted in the bathroom, and "it there." At this time a stale ad in the bathroom. a.m. the bathroom of R65 and have a strong odor of stale		The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by facility of the truth of the facts alleged conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of State and Federal law. Without wait the foregoing statement, the facility state that: a) With respect to R#51 and R#65, the bathroom has been thoroughly cleaned.	ed the on of uted ons ving ates

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F 253	urine. The director of [DES] reported the chronic issue. The linformed him they of the gentlemen in the when urinating. The be with the grout or time the backsplash away from the wall finding. The 7 Step Daily W dated 1/1/2000, dire Supplies.", "2. Emp 4. Clean and Sanitize the Co Walls and/or Partition Floor." 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive assenter disciplinary teal physician, a registe for the resident, and disciplines as deter and, to the extent p	of environmental services odor from the bathroom was a DES stated housekeeping had clean the bathroom, and then e room miss the toilet bowl DES reported the issue may a the floor or the toilet. At this a against the sink was coming and the DES confirmed this ashroom Cleaning procedure, ected staff "1. Check ty Trash", 3. Dust Mop Floor", ze Sink and Tub", "5. Clean immode.", "6. Spot Clean ons" and "7. Damp Mop O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 2		and back splash was repaired. b) Cleaning procedure has been reand revised. c) Housekeeping staff will receive re-education on the cleaning procedd) Healthcare Services Manager/Designee will audit 3 resigneems per week for 8 weeks to enscleanliness. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed b for 3 months. f) ED/Designee is responsible for completion.	dures. dent sure y IDT	8/11/15
	the resident, the res	sident's family of the resident's					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		STRUCTION	(X3) DATE SURVEY COMPLETED	
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F 280	Continued From palegal representative and revised by a tereach assessment. This REQUIREME by: Based on docume facility failed to rev 1 of 1 residents (Repositioning and fail of 1 resident (R69) Findings include: R43's care plan was change for restoral R43's care plan da mobility "Limited playing thumeral arm history and history Requires 2 staff as R43's admission M 2/13/15, indicated	, 	F 2	The corr cons as a facil cond defice prep sole of S the state was and b) W	e preparation of the following plection for this deficiency does restitute and should not be interputed and should not be interputed and structure and agreement ity of the truth of the facts allegularished clusions set forth in the statement ciencies. The plan of correction pared for this deficiency was exply because it is required by protate and Federal law. Without foregoing statement, the facility	an of not reted by the ed on ent of neuted visions waiving a states thensive plan ulation	
	(ADL's). R43 was discharge 4/10/15, with a note Progress and Disc 15 feet with L hall r care giver assistant ambulate x 300 feet walker) with MOD	ed from physical therapy ation on a form titled, Therapist harge Summary, to "ambulate ailing on even surfaces with ce. The long term goal read; et with FWW (front wheeled (moderate) (1) in order to live ther ALF (assisted living		c) Li on r Plar d) T care resid	sal of cares. icensed staff will receive re-edu eviewing and revision of the Ca	esident tre	

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	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN	CODE	
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F 280	facility) or SNF (ski Furthermore, the di Training provided R43's plan of care potential for impair pressure ulcer devulcer at this time rafragile skin, inconti oxygen dependent assistance with beand ambulation." Tiencourage repositions related to the plan of care directed staff to "Rin bed and every 3 wheelchair every simple was wearing grippe foot pedals on the offered to stand or during the observation of pedals on the offered to stand or during the observation of pedals on the offered to the dini a.m. R43 was wheeled to the dini a.m. R43, with 1 st to bed. When internursing assistant (6:30 a.m. into the visit of the dini as to the offered as a sistent (6:30 a.m. into the visit of the dini a.m. R43, with 1 st to bed. When internursing assistant (6:30 a.m. into the visit of the dini as the pedal of the dini as a sist and the pedal of the dini as a sist and the pedal of the dini a.m. R43 was when a.m. R43, with 1 st to bed. When internursing assistant (6:30 a.m. into the visit of the pedal of the dini as a sist and the pedal of the pedal of the dini as a sist and the pedal of the	age 22 illed nursing facility)." ischarge summary read, to some of the nursing staff." also directed staff; "[R43] has ment to skin integrity and elopment with actual pressure to (related to) advanced age, nence, functional decline, by, edema, and requiring domobility, transfers, hygiene, the Intervention read, tion/position changes during Rounds." There were no other to positioning in the wheel chair, however, the treatment sheet eposition every 2 hours when to minutes when up in hift. Start date 4/2/15." Ition on 6/29/15, at 4:45 p.m., the dining room table. R43 er socks, and there were no wheel chair. R43 was not change position from the staff tion period from 4:45 p.m. until tion from 7/1/15 from 7:00 a.m. was seated in a wheel chair at ator. At 7:30 a.m. R43 was ng room for breakfast. At 8:30 eled to the bedroom. At 8:40 a.m., NA)-A, verified R43 was up at wheelchair and there were no osition or offload buttocks,	F 2	and refusal of care. e) Results of these audits of documented in the facility's assurance meeting and refor 3 months. f) DNS/Designee is responded to the facility's assurance meeting and refor 3 months.	s quality viewed by IDT	

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F 280	time. NA-A, acknow sheet did not specifiand stated NA-A we been informed that change every 30 m validated R43 was position while seate when settled into be creases and crevice buttocks area from numerous red creato posterior thighs a incontinent of urine	r and ten minute period of vledged the aide assignment fy half hour position changes orked full time and had never R43 required a position inutes. Furthermore, NA-A not able to physically change ed. Observation of R43s' skin ed at 8:45 a.m., revealed red es to posterior thighs and the brief. NA-A verified the ses and crevices were present and buttocks. R43 was not at this time. LPN-A proceeded nange to the superior right	F 280			
	nursing assistant (N 6:30 a.m. into the woffers to change poduring this two houtime. NA-A, acknowsheet did not specifiand stated NA-A webeen informed that change every 30 m validated R43 was position while seated linterview on 7/2/14 who worked full tim aware R43 was to 8 30 minutes, while s	, at 11:00 a.m., with NA-B, e, also verified not being nave a position change every eated, and validated the aide did not inform staff to change				

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F 280	Review of R69's me physician order for Record in point clicl gain 3 lbs/24 hrs (3 lbs/week or wgt exc weight (414.4 lbs)." administration recorrefused to be weight of R69's May 2015 refused to be weight Review of R69's pha physician order for [continuous positive keep airways open, breathing problems [hour of sleep] off Afacemask (not nasatubing. Pressure 8 need: Indefinite. Mu R69's June MAR indevery day in June. When interviewed of licensed practical needs.	edical record indicated a "daily am (morning) weights. K. Notify MD for wgt (weight) pounds in 24 hours) 5 reeding 10 lbs from admission Review of the medication rd (MAR) indicated R 69 red every day in June. Review MAR indicated the resident	F 28	30		
F 309 SS=D	weights, and refuse LPN-C verified R69 the plan of care, an 483.25 PROVIDE C HIGHEST WELL BI Each resident must provide the necessar	d to wear the CPAP at night. 's refusal of care was not on d should have been. CARE/SERVICES FOR EING receive and the facility must ary care and services to attain	F 30	09		8/11/15
	or maintain the high	est practicable physical,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309	mental, and psychological accordance with the and plan of care. This REQUIREME by: Based on record resided to ensure canursing assessment (R55) who well, and who expired ay. Findings include: Review of Progress been admitted to the	osocial well-being, in e comprehensive assessment NT is not met as evidenced eview and interview, the facility re, including a thorough nt, was provided for 1 of 1 o complained of not feeling red unexpectedly the following so Notes revealed that R55 had ne facility 4/14/15, with	F3	The preparation of the following correction for this deficiency of constitute and should not be if as an admission nor an agree facility of the truth of the facts conclusions set forth in the standericiencies. The plan of corresponding to this deficiency we solely because it is required by the foregoing statement, the foregoing statement, the foregoing statement.	loes not interpreted ement by the alleged on atement of ection as executed y provisions hout waiving		
	obstruction, diabeted bipolar disorder, and A late entry Progres included; "Shortly be the resident unrespulse and not breath his vitals which we were taken due to previous night" Review of the reconursing assessment including; recent viresident's specificate feeling well, or any nursing assessment documentation in F	es that included: chronic airway es, heart failure, hypertension, and sleep apnea. Ses Note dated 4/26/15, before 1000 this nurse found consive in his room without a thing. Prior to this time we took are within normal limits. Vitals him not feeling well over the ard lacked documentation of the complaints when he was not other documentation of a the complaints when he was not other documentation of a the complaints when he was not other documentation of a the complaints when he was not other documentation of a the complaints when he was not other documentation of a the complaints when he was not other documentation of a the complaints when he was not other documentation of a the complaints when he was not other documentation of the complaints when he was not other documentation of a the complaints when		a) With respect to R#55, the r responsbile for failing to docu change of condition is no long at the facility. b) Licensed staff will receive r on documenting a resident's condition. c) DNS/Designee will audit 2 records for change in condition for 4 weeks then 1 resident reweek for 4 weeks. d) Results of these audits will documented in the facility's quassurance meeting and review for 3 months.	ment a ler employed e-edcuation change in resident n per week cord per be ality		

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	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 310 SS=G	pressure document was only one oxyge and that had occurr note from a nurse prindicated the reside breath sounds." R55 complained of 4/25/15 and expired When interviewed director of nursing (cared for this reside facility. At 9:00 a.m. further documentatilocated regarding that to R55's unexpecte 483.25(a)(1) ADLS UNAVOIDABLE Based on the compresident, the facility abilities in activities unless circumstance condition demonstrunavoidable. This is to bathe, dress, and ambulate; toilet; ear or other functional of This REQUIREMENT.	n after 4/18/15, and no blood ation after 4/24/15. There in saturation level documented ed on 4/16/15. An acute visit practitioner, dated 4/24/15, and had been seen for "coarse not feeling well the night of d unexpectedly on 4/26/15. In 7/1/15, at 8:32 a.m. the DON) stated the nurse who ent no longer worked at the the DON stated that no ion of assessment could be ne events that occurred prior	F3	e) DNS/Designee is responsible completion	or	8/11/15
	review, the facility fa ambulation progran	ion, interview and document ailed to implement an n to improve or maintain a ambulate for 1 of 1 resident		The facility does not agree with values facts and conclusions in the state deficiencies and licensing violatic seeking an appeal at this time. T	ment of ns and is	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245320	B. WING			07/0	2/2015
NAME OF	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	0.70	
WOODL	YN HEIGHTS HEALTI	HCARE CENTER			60 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 310	(R43) reviewed for facility to consister program resulted in decreased strengt. Findings include: R43 had been admit facility on 2/6/15, for the right humerus interagency transfer admission, R43 had the assisted living, A fourteen day mirred assessment dated in the corridor durit period, and had was a thirty day MDS of not walked in the right humerus in the corridor durit period, and had was a thirty day MDS of not walked in the right bedroom twice durited, Physical The 2/6/15, included; "In narrow base quad CGA (care giver as functioning Ambula quad cane on ever assist secondary to balance). Goal data According to the Pheen independent	rambulation. The failure of the ally implement an ambulation in harm for R43 who sustained in and inability to ambulate. Initted from an assisted living a fall and fracture of (upper arm). According to be redocumentation at the time of a been ambulating 300 feet at according to the therapy goals. Inimum data set (MDS) 2/20/15, R43 had not walked and the seven day assessment alked in the bedroom only once. Inited from an assisted living to according to the time of a seven and a set (MDS) 2/20/15, R43 had not walked and the seven day assessment alked in the bedroom only once. Inited from an assisted living to according to a set (MDS) 2/20/15, Indicated R43 had a seven day assessment and a seven day assessment and a seven day assessment and a seven day a sessment are a surfaced with a sessment and a seven documentation and a seven documentation are applied to a surface with a sessment and a seven documentation are applied to a surface with a sessment and a surface with a sessment and a series of the sessment and	F3	310	preparation of the following plan of correction for this deficiency does reconstitute and should not be interprated as an admission nore an agreement the facility of the truth of the facts as on conclusions set forth in the state of deficiencies. The plan of correct prepared for this deficiency was exsolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) R#43 received Physical Therapy date of admission until reaching a proof R#43 did not loose the ability to amfrom the date of discharge from the time of survey. b) All residents' ambulation programs have been reviewed and care plans revised if needed. c) The facility's communication too ambulation programs has been reviewed. d) Nursing and Therapy staff will rere-education regarding the use of the communication tool for ambulation programs. e) DNS/Designee will audit 2 residerecords regarding ambulation per very for 4 weeks then 1 resident record week for weeks. f) Results of these audits will be documented in the facility's quality	reted nt by alleged ement tion ecuted visions waiving retains the states of the states	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245320	B. WING _		07/	02/2015
	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5	CODE	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 310	R43 was discharge PT Discharge Sum provided to some of program." The curidentified as; "Ambrailing on even surnursing staff traine FMP (full mobility putherapy "Goal" inclified FWW (front wheeled (moderate) (1) in one either ALF (assisted nursing facility) set. During observation 6/29/15, R43 was rencouragement to R43 was seated at gripper socks, with chair. During an observation R43 was seated at gripper socks, with chair. During an observation R43 was seated to the dinical a.m., R43 was wheeled to the dinical a.m., R43 was R43 was only able seconds before stated the assistance of one soluring the observation at R43 had been at 6:30 a.m. without encouragement/as stated R43 was no steps. NA-A stated on the unit, but had on the unit, but had a stated R43 was no steps. NA-A stated on the unit, but had a stated R43 was no steps. NA-A stated on the unit, but had a stated R43 was no steps. NA-A stated on the unit, but had a stated R43 was no steps. NA-A stated on the unit, but had a stated R43 was no steps. NA-A stated on the unit, but had a stated R43 was no steps. NA-A stated on the unit, but had a stated R43 was no steps.	ed from PT on 4/10/15, and the imary included; "Training of the nursing staff for gait rent level of function was ulates 15 feet with L (left) hall faces with CGA, Some of the d in walking with patient for otential)." The physical uded; "ambulate 300 feet with ed walker) with MOD rder to live independently in d living facility) or SNF (skilled ting." Is from 4:45 p.m 6:00 p.m.on not offered assistance or stand or walk. At 5:15 p.m., the dining room table wearing no foot pedals on the wheel Ition 7/1/15 from 7:00 a.m. until is seated in a wheel chair by a lator. At 7:30 a.m. R43 was ng room for breakfast. At 8:30 leeled back to her bedroom. At observed during a transfer. Ito tolerate standing for 30 liting, "that's enough!" R43 was unsfer to her bed with the staff, nursing assistant (NA)-A. Ition, NA-A verified at 8:40 a.m. transferred into the wheelchair	F 31	assurance meeting and reversor 3 months. g) DNS/Designee is response completion.	·	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245320	B. WING			07/	02/2015
	PROVIDER OR SUPPLIER	CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 060 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 310	transfer 7/1/15, at 8 that staff did not am "They stopped walk F-A further stated F the assisted living pand said she was a ability to walk. During and said she was a ability to walk. During expressed a desire returning to the ass During an interview NA-B, another full the not realize R43 was During an interview (LPN)-A on 7/2/15 awas aware R43 couknow there was an At that time, register interviewed. RN-C who completed the stated R43 had been of 2 staff for walking had walked in the hobservation days disperiod (ARD) of 2/1 Additional record redischarged to the homerus fractur from the hospital, the 14 day MDS dated 4/12/15 no ambulation in the the observation per stated from the hospital of th	r-A was present during the 3:40 a.m., and acknowledged abulate R43. F-A stated, sing her." R43 had been independent in prior to the fractured right arm, fraid R43 would lose her ag this conversation, R43 to be walked in hopes of isted living. on 7/2/14, at 11:00 a.m., with ime staff, she stated she did a suppposed to ambulate. with licensed practical nurse at 11:30 a.m., she verified she ald take steps, but did not ambulation program for R43. Fred nurse (RN)-C was stated she was the person MDS assessments. She an admitted as extensive assist g in the room, and verified R43 allway five of the seven uring an assessment review 7/15. Review revealed R43 had been ospital for surgical repair of the on 3/12/15. Upon return the 5 day MDS dated 3/22/15, ted 3/29/15, and the 30 day all indicated there had been bedroom or hallway during		310			

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07	7/02/2015
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5507	_	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 310	Data Set (MDS) da cognitively intact wi activities of daily liv The nursing assistation indicated: "non ambitallway." When interviewed of physical therapy as possible the nursing completed and passexpressed training ambulate R43 using in the hallway. When interviewed of expressed not know acknowledged the because nursing hareferral from the the Additional information executive director of 7, 2015: "R43's ability to amsince her admission to right humeral fra repair of the humer the RUE [right uppersignificant laceration extremity] with eder "Point of Care Dock has never ambulate admission. She has ambulate in her rock."	thed 5/8/15, indentified R43 as the dependence on staff for ing (ADL). ant care sheet dated 7/1/15, pulatory for in room and on 7/2/15, at 1:12 p.m., the sistant (PTA) thought it was greferral sheet had not been sed on to the nurse. The PTA two nursing assistants to gethe left arm and the handrail on 7/2/15, at 1:20 p.m., RN-A wing R43 could walk and process had been "dropped" and not received the rehaberapy department. on was submitted by the of the facility, after survey, July bulate had been inconsistent in due to instability secondary current, then due to surgical all fracture with restrictions of er extremity] and then with a in to her LLE [left lower	F3			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245320	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
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F 310	discharge from phy did not achieve her with staff assistance distance of 15 feet assistance." "Resident R43 was 7/7/2015 for gait tra	intly in her bed mobility. Upon sical therapy 4/10/2015 R43 goal of ambulation 50 feet e but was ambulating a with contact guard referred to therapies on aining and to initiate a gait	F 310			
F 314 SS=D	level of function is r feet on even surfact left handrail and rig on therapies arm. F function demonstratimprove and did no walking program has currently receiving probability".		F 314		*	8/11/15
	resident, the facility who enters the facility does not develop p individual's clinical they were unavoidal pressure sores received.	orehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing.				
	by: Based on observat review the facility fa	NT is not met as evidenced tion, interview and document alled to offer timely f 1 resident (R43) who was		The preparation of the following place correction for this deficiency does reconstitute and should not be interpreted.	not	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245320	B. WING		07/02/2015	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLÉTION	
F 314	Continued From pa	ge 32	F 314			
	ulcers and develop admission to the fa Findings include:	isk for developing pressure ed a pressure ulcer after cility. 2/6/15, from an assisted living		as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was exsolely because it is required by proof State and Federal law. Without	ent of n eccuted visions	
	facility, due to a non humerus (upper arr	n-repaired fracture of the right m,) with instructions to wear a m with limited mobility.		the foregoing statement, the facility that:	/ states	
	Data Set (MDS) da was cognitively inta activities of daily liv indentified R43 was pressure ulcers. Th	f R43's admission Minimum ted 2/13/15, indicated R43 ct and was dependent with ing (ADL's). The MDS at risk for the development of were were no unstageable skin sure ulcers identified.		a) With respect to R#43 a compreh assessment has been performed. plan has been reviewed and revise related to repositioning. Wound treand monitoring was initiated with the discovery of the pressure area. Ar continues to show improvement.	Care ed eatment ne ea	
	an unstageable pre 8:35 a.m. and read morning by the atte assistant/registered [R43's] right gluteal	ation that identified R43 had ssure ulcer was 3/1/15, at , "[R43] was found this ntion of the NA/R (nursing d) with three open areas to fold. Area #1 (Superior) centimeter) x 1.5 cm. Area #2		 b) Residents have a comprehensive assessment completed upon admit quarterly and with a significant chatch. c) Nursing staff will receive re-educated to care plan interventions, repositioning, and skin observation. 	ssion, nge. uation	
	(Medial) measures (Posterior) measure applied to Superior applied to medial a unstageable, dark a #2 and #3 beefy red	3 cm x 1 cm. Area #3 es 1 cm x 2 cm. Allevyn thin area, protective ointment nd posterior areas. Area #1 area present over area. Area d. No C/O's (complaints of) he area. Will update MD and		 d) DNS/Designess will audit 2 residence records per week related to pressure areas and repositioning for 4 week 1 resident record for 4 weeks. e) Results of these audits will be documented in the facility's quality assurance meeting and reviewed before 2 months. 	ire s then	
	notes was made or read; "[R43] right be	cumentation in the progress a 3/4/15, at 7:40 p.m., and uttock presents with three ost superior is unstagable,		for 3 months. f) DNS/Designee is responsible for completion.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245320	B. WING _			07/02/2015	
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	surrounded by beef blancheable. Media shearing. Allevyn G placed atop superior prep applied to med protect skin. [R43] of the areas palpated ask am staff tomorn Allevyn and Skin processary of the areas palpated ask am staff tomorn Allevyn Gentle Bord (MAR) dated 3/1/15 Allevyn Gentle Bord wound) change even necessary) on 3/4/1 medication sheet is medial and inferior Apply every shift. Toward MAR on 3/4/15, 3-1 R43 was seen at the 9:42 a.m. and the perior being seen at the V coccyx wound." The tissues were sharpled condition, stimulated overall bacteria load decrease edge sent Review of R43's, O 4/2/15, identified a gevery 2 hours when when up in wheelch	firm cap of slough. It is by redness. Peri wound is all buttock with are of [sic] tentle Border dressing (small) or wound. 4 Layers of skin dial and inferior areas to denies discomfort with any of or treatment performed. Will row to call for orders for the ep orders." Ilication Administration Record 6-3/31/15, begins to sign out der to (R) buttock (Superior ery 3 days and prn (whenever 15. The next direction on the for 4 layers skin prep to areas of shearing (R) buttock. his is first signed out on the 1 shift. Le wound clinic on 4/2/15 at chysician note read, "[R43] is ascular Clinic today regarding to epidermal and dermal y debrided for a total square 10. Devitalized and non viable at to improve granulation tissue to wound healing, decrease d, disrupt biofilm formation and scence." Treder Summary Report, dated physician order, "reposition in bed and every 30 minutes	F3				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245320	B. WING		07/0	02/2015		
	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 314	when in bed and every so Although the treath reposition R43 every wheelchair, review sheet dated, 6/30/1 hours. During an observation R43 was seated at was wearing gripped foot pedals on the offered to stand or during the observation of the electron of	d, "Reposition every 2 hours very 30 minutes when up in shift. Start date 4/2/15." nent record directed staff to ry 30 minutes when up in the of the nursing assistant care 15, read, "reposition every 2 tion on 6/29/15, at 4:45 p.m., the dining room table. R43 er socks, and there were no wheel chair. R43 was not change position from the staff tion period from 4:45 p.m. until tion from 7/1/15 from 7:00 a.m. awas seated in a wheel chair at ator. At 7:30 a.m. R43 was ng room for breakfast. At 8:30 eled to the bedroom. At 8:40 aff assistance, was transferred viewed on 7/1/15, at 8:40 a.m., NA)-A, verified R43 was up at wheelchair and there were no osition or offload buttocks, r and ten minute period of wledged the aide assignment fy half hour position changes orked full time and had never R43 required a position inutes. Furthermore, NA-A not able to physically change ed. Observation of R43s' skin ed at 8:45 a.m., revealed red es to posterior thighs and the brief. NA-A verified the ases and crevices were present	F 314					

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245320	B. WING			07/0	02/2015
	PROVIDER OR SUPPLIER	ICARE CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE D60 UPPER 55TH STREET EAST IVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	(X5) COMPLETION DATE
F 314	incontinent of urine with the dressing of buttock. Review of wound mand documentation which read; "1.6 x granulation tissue. probing of wound be 2 gauze pad cut in acid. Placed in wound pad and secured where the largest measurate a were recorded 3/15/15, as 4.3 x 2. =/> [sic] 2.6 cm. Do notes indicated the buttock wounds here decubitus was measured buttock wounds here decubitus was measured to the avoid the chair and air buring an interview.	and buttocks. R43 was not at this time. LPN-A proceeded hange to the superior right neasurements from 6/30/15 from the Skin/Wound note 1 x 0.2 cm (centmeter) 100% No tunneling noted with gentle ed. Cleansed. Patted Dry. 2 x half and moistened with acetic and bed. Covered with ABD ith hypafix tape." Tements for the right superior of in the progress notes 5 cm. (centimeter) Depth is becumentation in the progress right medial and right inferior aled 3/18/15. The superior issured on 6/30/15, as 1.6 at 20 depth in centimeters. The superior issured on 3/6/15, 3/9/15, and care physician to R43 on the form titled, and Care for Seniors dated ere was no mention of any ites. Furthermore the physician to R43 on 3/6/15, 3/9/15, and did not address any ites. On 3/27/15, the physician of skin involving buttock for request referral to wound etc. Additionally, load-off cushion mattress are to be obtained."	F3	14			
	(DON), registered r	nurse (RN)-A and RN-C on					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245320	B. WING _		07/	02/2015
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	information available inspections associated unstageable wound the facility documer progress notes a st associated with the and if there was no other documentation. The undated facility Skin and Positioning Defined Assessment because the facility there were wounds. Interview on 7/2/14, who worked full times.	n., there was no data or le indicating specific skin lated with bathday prior to the discovery 3/1/15, because need in the computerized atement which read, "bruises" admission right arm fracture, skin issue, there would be no no. Topolicy, titled, Comprehensive g Evaluation UDA (User needs) and used for R43 did not use the form until according to the DON. Topolicy, at 11:00 a.m., with NA-B, e, also verified not being	F 3 ⁻¹	4		
F 329 SS=D	aware R43 was to h 30 minutes, while s assignment sheet of R43's position every 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequent should be reduced combinations of the	nave a position change every eated, and validated the aide lid not inform staff to change y half hour. EGIMEN IS FREE FROM RUGS g regimen must be free from and an unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of the excession of the excess	F 32	29		8/11/15

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245320	B. WING			07/0	02/2015
	PROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 160 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	given these drugs therapy is necessar as diagnosed and record; and reside drugs receive grade behavioral interver contraindicated, in drugs. This REQUIREME by: Based on record residents (R1, R69 have monitoring of related to the use of the residents to the reside	age 37 I antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical nts who use antipsychotic ual dose reductions, and utions, unless clinically an effort to discontinue these NT is not met as evidenced eview and interview 2 of 10) medications reviewed did not specific target behaviors of the anti-anxiety medication and did not assure physician	F3	329	The preparation of the following placorrection for this deficiency does not constitute and should not be interpretated as an admission nor an agreement facility of the truth of the facts allege	ot eted by the	
	order for clonazepa at bedtime for para medication admini- and July, 2015, revourrently receiving administration reco 2015 read, "Target agitation" There behavior listed. Tharget behavior relacurrent plan of care	ealed a 5/12/15, physician's am 1 milligram (mg) by mouth moid schizophrenia. The stration records for June, 2015 realed the resident was this medication. The treatment ords for June, 2015 and July, Behavior #1- (Clonazepam) were no details of this mere was no reference to a sted to clonazepam use on the			conclusions set forth in the stateme deficiencies. The plan of correction prepared for this deficiency was exessolely because it is required by provof State and Federal law. Without withe foregoing statement, the facility that: a) With respect to R#1, resident's caplan has been reviewed and revised reflect appropriate target behaviors related to the use of psychoactive medications. b) With respect to R#69, resident's sugar and blood pressure parameter were reviewed with MD.	ecuted visions vaiving states are d to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		SURVEY PLETED
		245320	B. WING			07/0	02/2015
NAME OF I	PROVIDER OR SUPPLIEF	}		S	TREET ADDRESS, CITY, STATE, ZIP CODE		7_7_010
WOODLY	/N HEIGHTS HEALT	HCARE CENTER			060 UPPER 55TH STREET EAST NVER GROVE HEIGHTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	licensed practical manager for this ubehaviors R1 dem replied R1 refused and can't stop talk R69's medical recensuring adequate Review of R69's M7/1/15, indicated a accuchecks, call M (nurse practitioner or greater that 400 administration recindicated fifteen rebeen recorded. Honotes for the montindication of MD of glucose readings of Review of R69's M7/1/15, indicated a Tartrate [medication of MD of glucose readings of Review of R69's M7/1/15, indicated a Tartrate [medication of MD of glucose readings of Review of R69's M7/1/15, indicated a Tartrate [medication g8a and 8p holopressure] less that for June, 2015 indicated pressure was 109, not held. There was had been retaken for June, 2015, lact the low blood pressures with the low blood pressures to call the Mgreater than 400.	nurse (LPN)-C, the nurse init, was asked what specific constrated with agitation. She discares, could be delusional, ing. ord lacked documentation e monitoring of medications. Medication Review Report dated a physician order for MD (doctor of medicine) or NP of the blood glucose less than 75 of A review of R69's medication ord (MAR) for June, 2015 adings greater than 400 had owever, a review of progress the of June, 2015, lacked or NP notification of blood	F3	329	c) All residents receiving psychoac medications have been reviewed to assure that there are appropriate indications for the use of these medications and that target behavior identified. Care plans updated as red. Licensed staff will receive re-educed regarding the use of psychoactive medication. e) Licensed staff will receive re-educed on notification of MD. f) DNS/Designee will audit 2 reside records for target behaviors per weak weeks then 1 resident record for weeks. g) Results of these audits will be documented in the facilty's quality assurance meeting and reviewed by for 3 months. h) DNS/Designee is responsible for completion.	ors are needed. ucation ucation et for 4	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X3	3) DATE SURVEY COMPLETED
		245320	B. WING		07/02/2015
	PROVIDER OR SUPPLIER	CARE CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST NVER 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 329	medication per para low blood pressure	s for the nurse to hold the ameters, and follow up on the	F 329		0/44/45
F 428 SS=D	The drug regimen of reviewed at least of pharmacist. The pharmacist muthe attending physic nursing, and these	of each resident must be note a month by a licensed ast report any irregularities to cian, and the director of reports must be acted upon.	F 428		8/11/15
	by: Based on documer facility's consulting facility of irregulariti specific target behavior anti-anxiety medical reviewed for unnectative for unnectative for clonazepa milligram (mg) by nochizophrenia. The records for June, 2 R1 was currently retreatment administrand July, 2015 reactative facility is consulted in the second of the second for June, 2 R1 was currently retreatment administrand July, 2015 reactive facility is consulted in the second of the second facility is second for June, 2 R1 was currently retreatment administrand July, 2015 reactive facility is second facility in the second facility is second facility in the second facility is second facility.	Intreview and interview, the pharmacist did not advise the es regarding the lack of aviors related to the use of an ation for 1 of 5 residents (R1) essary medications. In alled a 5/12/15, physician's am (anti-anxiety medication) 1 mouth at bedtime for paranoid medication administration 2015 and July, 2015, revealed aceiving this medication. The ration records for June, 2015 dt, "Target Behavior #1-ation" There were no details		The preparation of the following plan correction for this deficiency does not constitute and should not be interprete 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 was the foregoing statement, the facility state: a) With respect to R#1, a medication review was completed by consulting pharmacist. b) All residents receiving psychoactives	ed the on of uted ions iving ates

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		E SURVEY PLETED
		245320	B. WING		07/	02/2015
	PROVIDER OR SUPPLIER /N HEIGHTS HEALTI			STREET ADDRESS, CITY, STATE, ZIP 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	of this behavior list a target behavior r the current plan of When interviewed licensed practical manager for this u behaviors R1 dem replied R1 refused could not stop talk. The Record of Med dated 5/19 and 6/1 pharmacist had reverence However, there we recommendations the lack of specific this resident. During a telephone p.m. the facility's casked if she looked with the use of psy reviewing resident pharmacist replied specific target behaviors. The sur Consultant Pharma Nursing for this resincluded the recomspecific Target Behother psychoactive taking at that time, explained she had facility about this reconsultants for the	ted. There was no reference to elated to clonazepam use on care for this resident. on 7/2/15, at 2:04 p.m. hurse (LPN)-C, the nurse nit, was asked what specific constrated with agitation. She care, could be delusional, and ing. dication Regimen Review form 8/15, revealed the consulting viewed R1's drug regimen. For eno notes or found in the record regarding target behavior of agitation for einterview on 7/2/15, at 2:25 consulting pharmacist was d for specific target behaviors in the consulting that she did look for the aviors and made to use specific target reveyor mentioned there was a facist Communication to sident on 2/21/15, which in mendation to use "patient naviors" for the use of several emedications that R1 was The consulting pharmacist spoken with the staff at the equirement and the nurse facility stated were working on umentation of appropriate	F 4	medications have been revasure that there are approindications for the use of the medications and that targe identified. Care plans updated: c) Nursing staff will receive regarding the use of psychmedications. d) DNS/Designee will audit records for target behavior 4 weeks then 1 resident reweeks. e) Results of these audits adocumented in the facility's assurance meeting and refor 3 months. f) DNS/Designee is responded to the completion.	opriate nese it behaviors are ated as needed. e re-education oactive t 2 resident is per week for cord for 4 will be quality viewed by IDT	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245320	B. WING			07/	02/2015
	PROVIDER OR SUPPLIER	CARE CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 SS=D	The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological abeled in accordant professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and permit have access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whele package drug districts.	nploy or obtain the services of sist who establishes a system at and disposition of all sufficient detail to enable and sion; and determines that drug and that an account of all maintained and periodically als used in the facility must be acceved with currently accepted ales, and include the ory and cautionary are expiration date when State and Federal laws, the all drugs and biologicals in ants under proper temperature at only authorized personnel to keys. To vide separately locked, and compartments for storage of and other drugs subject to an the facility uses single unit bution systems in which the inimmal and a missing dose can	F 4	31			8/11/15
	by:	NT is not met as evidenced ion, interview and document			The preparation of the following pla	an of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245320	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	medications were read medication carts 3 residents (R8, R2). Findings include: Review of the medion 6/29/15, at 12:33 discovered: an ope R8, with an opened prior); an open bott medicine), 200 milli with an unreadable expiration date of 3. Registered nurse (Filter were expired and so direction label on the unreadable. Review of the medion 6/29/15, at 12:53 discovered: an open R40, with an open eprior.) Licensed Practical date and indicated should not be used. Review of R8's reconstruction and review of R8's	id not ensure four expired emoved from storage for 2 of reviewed, potentially affecting (2, R40). cation cart for the 600 hallway, 5 p.m. the following were n bottle of Levemir insulin for 1 on date of 5/12/15, (48 days le of guaifenesin (cough gram (mg) tablets for R22, direction label, and an /15. RN)-B verified the medications hould not be used, and the le bottle of guaifenesin was cation cart for the 500 hallway, 3 p.m., the following were n bottle of Lantus insulin for 1 on date of 5/22/15. (38 days) Nurse (LPN) - E verified the the insulin was expired and 1 cord indicated a physician order in (Insulin Detemir) Inject 28 of the cord indicated a physician in tablet 400 mg tablet oral	F 43	correction for this deficiency does constitute and should not be interpas an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed deficiencies. The plan of correction prepared for this deficiency was expolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that: a) With respect to R#8, R#22 and an audit has been performed to enthat there no expired medications. b) All facility medicaiton carts will be audited to ensure all expired medication that have been removed and disconting c) Licensed staff will receive reed on the facility's medication expiration procedure. d) DNS/Designee will audit 1 medicart per week for 8 weeks for expirmedications. e) Results of these audits will be documented in the facility's quality assurance meeting and reviwed by for 3 months. f) DNS/Designee is responsible for completion.	reted t by the ged on ent of e	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY MPLETED
		245320	B. WING		07/	02/2015
	PROVIDER OR SUPPLIER	CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55	, STATE, ZIP CODE REET EAST HTTS, 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	order for Lantus So 8 unit subcutaneou diabetes. The Medication Exp March 2015, indica expiration date of 3 procedure also indi	cord indicated a physician lution (Insulin Glargine) Inject sly one time a day related to biration Procedure dated ted insulin vials had an 0 days after opening. The cated medications would be date of expiration the	F 4	31		

F5320024

Printed: 07/06/2015 FORM APPROVED OMB NO. 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

07/01/2015

NAME OF PROVIDER OR SUPPLIER

WOODLYN HEIGHTS HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

		INVER GROVE HE	NVER GROVE HEIGHTS, MN 55077					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	ID GULATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE				
K 000	INITIAL COMMENTS	K 000						
	FIRE SAFETY							
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Fi Marshal Division on July 01, 2015. At the ti this survey, Woodlyn Heights Healthcare C was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 20 edition of National Fire Protection Associat (NFPA) Standard 101, Life Safety Code (Life Chapter 19 Existing Health Care.	re ime of Center he						
	The Woodlyn Heights Healthcare Center is 2-story building with no basement. The buwas built in 1973 and was determined to be Type II(111) construction. In 2014 a single addition was added to the East and was determined to be of Type II(111) construction.	ilding e of story		***************************************				
	This facility was surveyed as two separate buildings because of different dates of construction. Building 1 was constructed properties of March 1, 2003. Therefore, it was surveyed accordance with LSC Chapter 19, and build was surveyed in accordance with LSC Chapter 18.	in ding 2						
	The builfing is fully fire sprinklered. and had alarm system with full corridor smoke deter and spaces open to the corridor that is more for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 72 beds at the time of the survey	ction nitored The						
LABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTA	ATIVE'S SIGNATURE	TITLE	(X6) DATE				

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: 07/06/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2014 ADDITION (X3) DATE SURVEY COMPLETED

245320

B. WING

07/01/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WOODLYN HEIGHTS HEALTHCARE CENTER

2060 UPPER 55TH STREET EAST

		INVER GROV	E HEIGH	TS, MN 55077	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RI OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K	000		
	A Life Safety Code Survey was conducte Minnesota Department of Public Safety, I Marshal Division on July 01, 2015. At the this survey, Woodlyn Heights Healthcare was found in substantial compliance with requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (Chapter 19 Existing Health Care.	Fire time of Center the 2000 ation			
	The Woodlyn Heights Healthcare Center 2-story building with no basement. The bases built in 1973 and was determined to Type II(111) construction. In 2014 a single addition was added to the East and was determined to be of Type II(111) construction.	ouilding be of e story			
	This facility was surveyed as two separat buildings because of different dates of construction. Building 1 was constructed March 1, 2003. Therefore, it was surveye accordance with LSC Chapter 19, and bu was surveyed in accordance with LSC Ch 18.	prior to d in ilding 2			
	The builfing is fully fire sprinklered. and halarm system with full corridor smoke det and spaces open to the corridor that is m for automatic fire department notification. facility has a capacity of 99 beds and had census of 72 beds at the time of the survey.	ection onitored The	and the second control of the second control		
! :		: •			
LABORATOR	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESEN	TATIVE'S SIGNATURE	<u> </u>	TITLE	(X6) DATE

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted July 16, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5320025

Dear Ms. Donahue:

The above facility was surveyed on June 29, 2015 through July 2, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5320042 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

Woodlyn Heights Healthcare Center July 16, 2015 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

00829

(X3) DATE SURVEY COMPLETED

B. WING _

A. BUILDING:

07/02/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

			REET EAST	
VOODL	INVER GR	OVE HEIGH	ITS, MN 55077	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 000	Initial Comments	2 000		
	*****ATTENTION*****			
	NH LICENSING CORRECTION ORDER			
	In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.			
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.			
	You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.			
	INITIAL COMMENTS: The facility has 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 delineated on the attached Minnesota		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/24/15

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE S	
		00829	B. WING		07/02	2/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, §	STATE, ZIP CODE		72010
WOODLY	YN HEIGHTS HEALTH	CARE CENTER	PER 55TH ST ROVE HEIGH	REET EAST HTS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT 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 APPROPROFICE (PROSS-REFERENCE) (PROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	electronically. Althous necessary for State the word "corrected Then indicate in the process, under the date your orders will electronically subm Department of Heal A complaint investig	gation was conducted to nt #H5320042. The complaint		The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficienci column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met as evidenced by." Following the survivindings are the Suggested Method Correction and the Time Period For Correction.	Tag." the tute/rule ies" ply" his s which after the s veyors d of	
				PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTAS STATUTES/RULES.	THIS O ON FOR	
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			8/11/15
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal				

Minnesota Department of Health

STATE FORM 6899 1RUJ11 If continuation sheet 2 of 43

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00829 B. WING 07/02/2	2015
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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) X40 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to review and revise the care plan for 1 of 1 residents (R43) for ambulation and positioning and failed to revise the care plan for 1 of 1 resident (R69) for refusing weights. Findings include: R43's care plan was not updated to reflect a change for restorative nursing ambulation. R43's care plan dated, 2/18/15, directed staff for mobility "Limited physical mobility rit (related to) right humeral arm fracture, advanced age, fall history and history of vertigo. Ambulation: Requires 2 staff assistance for mobility" R43's admission Minimum Data Set (MDS) dated 2/13/15, indicated R43 was cognitively intact and was dependent on staff for activities of daily living (ADL's). R43 was discharged from physical therapy 4/10/15, with a notation on a form titled, Therapist Progress and Discharge Summary, to "ambulate 15 feet with L hall railing on even surfaces with care giver assistance. The long term goal read; ambulate x 300 feet with FWW (front wheeled walker) with MOD (moderate) (1) in order to live independently in either ALF (assisted living	

Minnesota Department of Health

STATE FORM 6899 1RUJ11 If continuation sheet 3 of 43

Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00829	B. WING		07/	02/2015
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	ICARE CENTER 2060 UPP	ER 55TH STI	TATE, ZIP CODE REET EAST TS, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 570	"Training provided to R43's plan of care a potential for impairs pressure ulcer deve ulcer at this time r/t fragile skin, incontin oxygen dependenc assistance with bed and ambulation." To "Encourage reposit Customer Service I directions related to on the plan of care, directed staff to "Refin bed and every 30 wheelchair every slowheelchair ever	to some of the nursing staff." also directed staff; "[R43] has ment to skin integrity and elopment with actual pressure (related to) advanced age, nence, functional decline, y, edema, and requiring dimobility, transfers, hygiene, he Intervention read, ion/position changes during Rounds." There were no other positioning in the wheel chair however, the treatment sheet eposition every 2 hours when in minutes when up in hift. Start date 4/2/15." ion on 6/29/15, at 4:45 p.m., the dining room table. R43 er socks, and there were no wheel chair. R43 was not change position from the staff ion period from 4:45 p.m. until ion from 7/1/15 from 7:00 a.m. was seated in a wheel chair at attor. At 7:30 a.m. R43 was no groom for breakfast. At 8:30 eled to the bedroom. At 8:40 a.m., NA)-A, verified R43 was up at wheelchair and there were no estition or offload buttocks, or and ten minute period of wledged the aide assignment for half hour position changes	2 570			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00829	B. WING		07/0	02/2015
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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) COMPLETE DATE
2 570	and stated NA-A we been informed that change every 30 m validated R43 was position while seate when settled into be creases and crevice buttocks area from numerous red creato posterior thighs a incontinent of urine with the dressing chattock. When interviewed nursing assistant (N6:30 a.m. into the woffers to change poduring this two hour time. NA-A, acknow sheet did not specifiand stated NA-A we been informed that change every 30 m validated R43 was position while seated. Interview on 7/2/14, who worked full tim aware R43 was to had not specifiant as the seated.	orked full time and had never R43 required a position inutes. Furthermore, NA-A not able to physically change ed. Observation of R43s' skin ed at 8:45 a.m., revealed red es to posterior thighs and the brief. NA-A verified the ses and crevices were present and buttocks. R43 was not at this time. LPN-A proceeded nange to the superior right on 7/1/15, at 8:40 a.m., NA)-A, verified R43 was up at wheelchair and there were no sition or offload buttocks, r and ten minute period of wledged the aide assignment fy half hour position changes orked full time and had never R43 required a position inutes. Furthermore, NA-A not able to physically change ed. at 11:00 a.m., with NA-B, e, also verified not being have a position change every eated, and validated the aide lid not inform staff to change				
	R69's plan of care v	was not updated to include e.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00829	B. WING	B. WING		2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0170	_,
WOODLY	/N HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 5	2 570			
	physician order for Record in point clic gain 3 lbs/24 hrs (3 lbs/week or wgt exc weight (414.4 lbs)." administration recorefused to be weight of R69's May 2015 refused to be weight Review of R69's pha physician order for [continuous positive keep airways opens breathing problems [hour of sleep] off Afacemask (not nasatubing. Pressure 8 need: Indefinite. Mu R69's June MAR in every day in June. When interviewed of licensed practical in refused to get out of weights, and refused LPN-C verified R69	edical record indicated a "daily am (morning) weights. k. Notify MD for wgt (weight) pounds in 24 hours) 5 ceeding 10 lbs from admission Review of the medication rd (MAR) indicated R 69 ned every day in June. Review MAR indicated the resident ned all but two days. ysician order record indicated or the following "CPAP e airway pressure (used to used by people who have s, such as sleep apnea)] on HS M: Heated humidifier, full all mask) head gear, filters and cm of H2O [water]. Length of ust wear nightly" Review of dicated R69 refused the CPAP on 7/2/15, at 10:27 a.m. urse (LPN)-C stated R69 of bed daily, refused daily ed to wear the CPAP at night. I's refusal of care was not on d should have been.				
	desigee could work team, MDS coordin review the assessn comprehensive car procuedure for care	of Correction: The DON or with the interdisciplinary ator and nurse managers to nents for accuracy, create e plans, review and revise the e plan updating, and then				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		07/0	02/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•		
WOODLY	/N HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, 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 SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ge 6	2 570				
	determine if the car comprehensive ass fashion and then ad	of resident records to re plans were based on sessment, updated in a timely occessible for staff.					
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			8/11/15	
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.						
	by: Based on record re failed to thoroughly assessment after 1 complained of not f unexpectedly the for Findings include: Review of Progress	eeling well and expired		No POC required.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00829		B. WING		07/0	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODLY	YN HEIGHTS HEALTH	ICARE CENTER	ER 55TH ST			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	bipolar disorder, an Progress Note, data before 1000 this nu unresponsive in his breathing. Prior to t which were within r	es, heart failure, hypertension, d sleep apnea. A late entry ed 4/26/15, read "Shortly arse found the resident room without a pulse and not his time we took his vitals normal limits. Vitals were of feeling well over the				
	Review of the record lacked documentation of recent vital signs, lacked nursing documentation of the resident's complaints when he was not feeling well, and lacked documetation of a nursing assessment. There was no nursing documentation in Progress Notes after 4/21/15, no temperature, pulse, or respiration documentation by nursing after 4/18/15, no blood pressure documentation after 4/24/15 and only one oxygen saturation level that was documented on 4/16/15. An acute visit note from a nurse practitioner, dated 4/24/15, indicated the resident was seen for "coarse breath sounds." R55 complained of not feeling well the night of 4/25/15 and expired unexpectedly on 4/26/15.					
	director of nursing of cared for this resident facility. At 9:00 a.m.	on 7/1/15, at 8:32 a.m. the (DON) stated the nurse who ent no longer worked at the . the DON stated that no ion could be located regarding urred prior to R55's				
	The director of nurs educate nursing sta care and supervision the resident's indivi	THOD OF CORRECTION: sing (DON) or designee could aff regarding providing nursing on for residents according to dual needs and assessment. Hee could monitor the care				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00829	B. WING	B. WING 07/		2/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODLY	'N HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, 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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	provided to residents and report the findings to the quality assurance committee.					
	TIME PERIOD FOR days.	R CORRECTION: Thirty (21)				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			8/11/15
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent yeloping.				
	by: Based on observation review the facility farepositioning to 1 or assessed to be at r	f 1 resident (R43) who was isk for developing pressure ed a pressure ulcer after		No POC required.		
	Findings include:					
	R43 was admitted 2	2/6/15, from an assisted living				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		07/0	2/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
WOODL	YN HEIGHTS HEALTH	CARE CENTER	ER 55TH ST ROVE HEIGH	REET EAST TS, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 9	2 900				
	facility, due to a non-repaired fracture of the right humerus (upper arm,) with instructions to wear a splint to the right arm with limited mobility.						
	Data Set (MDS) da was cognitively inta activities of daily liv indentified R43 was pressure ulcers. Th	f R43's admission Minimum ted 2/13/15, indicated R43 ct and was dependent with ing (ADL's). The MDS at risk for the development of the were no unstageable skin sure ulcers identified.					
	an unstageable pre 8:35 a.m. and read morning by the atte assistant/registered [R43's] right gluteal measures 1.5 cm ((Medial) measures (Posterior) measure applied to Superior applied to medial a unstageable, dark a #2 and #3 beefy red	ation that identified R43 had ssure ulcer was 3/1/15, at , "[R43] was found this ntion of the NA/R (nursing d) with three open areas to fold. Area #1 (Superior) centimeter) x 1.5 cm. Area #2 3 cm x 1 cm. Area #3 es 1 cm x 2 cm. Allevyn thin area, protective ointment and posterior areas. Area #1 area present over area. Area d. No C/O's (complaints of) the area. Will update MD and at to areas."					
	notes was made or read; "[R43] right be open areas. The m covered with thick, surrounded by beef blancheable. Media shearing. Allevyn G placed atop superior prep applied to med protect skin. [R43]	cumentation in the progress of 3/4/15, at 7:40 p.m., and auttock presents with three ost superior is unstagable, firm cap of slough. It is fay redness. Peri wound is all buttock with are of [sic] tentle Border dressing (small) or wound. 4 Layers of skin dial and inferior areas to denies discomfort with any of or treatment performed. Will					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 5507 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES EACH DEFIDENCIES THE LEGAL DEFIDENCIES (DENTIFYING INFORMATION) EACH CORRECTION EACH COMPLY AND FOR PREFIX TAG EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRIATE COMPLY TAG COntinued From page 10 ask am staff tomorrow to call for orders for the Allevyn and Skin prep orders." The form titled Medication Administration Record (MAR) dated 31/15-3/31/15, begins to sign out Allevyn Gentle Border to (R) buttock (Superior wound) change every 3 days and prn (whenever necessary) on 34/15. The next direction on the medication sheet is for 4 layers skin prep to medial and inferior areas of shearing (R) buttock. Apply every shift. This is first signed out on the MAR on 3/4/15, 3-11 shift. R43 was seen at the wound clinic on 4/2/15 at 9.42 a.m. and the physician note read, "[R43] is being seen at the Vascular Clinic today regarding coccyx wound." The epidermal and dermal tissues were sharply debrided for a total square cm (centimeter) of 10. Devitalized and non viable tissue was removed to improve granulation tissue formation, stimulate wound healing, decrease overall bacteria load, disrupt biolim formation and decrease edge senseence." Review of R43's, Order Summary Report, dated 4/2/15, identified a physician order, "reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift. Start date 4/2/15." Although the treatment record directed staft to reposition R43 every 30 minutes when up in the wheelchair, review of the nursing assistant care sheet dated, 6/30/15, read, "reposition every 2 bottom every 2 bottom every 2 bottom every 2 bottom every 3 minutes when up in the wheelchair, review of the nursing assistant care sheet dated, 6/30/15, read, "reposition every 2 bottom every 2 b	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
CALL DEPTITE STREET EAST INVERGROVE HEIGHTS, MIN 58077			00829	B. WING		07/0	2/2015
INVER GROVE HEIGHTS, MN 55077 SUMMARY STATEMENT OF ESPICIENCIES PLAN OF CORRECTION (EACH DEPRICED ON THIS PROVIDERS PLAN OF CORRECTION (EACH DEPRICED ON THIS PROVIDERS PLAN OF CORRECTION STOP PROVIDERS PLAN OF CORRECTION STOP PROVIDERS PLAN OF CORRECTION (EACH DEPRICED ON STOP PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CROSS REFERENCES PLAN OF PROVIDERS PLAN OF CROSS REFERENCES PLAN OF THE APPROPRIATE COMPANY OF THE PROVIDER PLAN OF PROVIDERS PLAN OF CROSS REFERENCES PLAN OF THE PROVIDER PLAN OF THE PRO	NAME OF	PROVIDER OR SUPPLIER					
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 10 ask am staff tomorrow to call for orders for the Allevyn and Skin prep orders." The form titled Medication Administration Record (MAR) dated 3//15-3/3/1/5, begins to sign out Allevyn Gentle Border to (R) buttock (Superior wound) change every 3 days and prn (whenever necessary) on 3/4/15. The next direction on the medication sheet is for 4 layers skin prep to medial and inferior areas of shearing (R) buttock. Apply every shift. This is first signed out on the MAR on 3/4/15, 3-11 shift. R43 was seen at the wound clinic on 4/2/15 at 9:42 a.m. and the physician note read, "[R43] is being seen at the Vascular Clinic today regarding coccyx wound." The epidermal and dermal tissues were sharply debrided for a total square cm (centimeter) of 10. Devitalized and non viable tissue was removed to improve granulation itsue formation, stimulate wound healing, decrease overall bacteria load, disrupt broilim formation and decrease edge senscence." Review of R43's, Order Summary Report, dated 4/2/15, identified a physician order, "reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift." The form titled, Treatment Record, for June 2015 and July 2015, read, "Reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift." The form titled, Treatment Record directed staff to reposition R43 every 30 minutes when up in the wheelchair, review of the nursing assistant care sheet dated, 6/30/15, read, "Reposition every 2	WOODL	N HEIGHTS HEALTH	CARE CENTER				
ask am staff tomorrow to call for orders for the Allevyn and Skin prep orders." The form titled Medication Administration Record (MAR) dated 3/1/15-3/31/15, begins to sign out Allevyn Gentle Border to (R) buttock (Superior wound) change every 3 days and prn (whenever necessary) on 3/4/15. The next direction on the medication sheet is for 4 layers skin prep to medial and inferior areas of shearing (R) buttock. Apply every shift. This is first signed out on the MAR on 3/4/15, 3-11 shift. R43 was seen at the wound clinic on 4/2/15 at 9:42 a.m. and the physician note read, "[R43] is being seen at the Vascular Clinic today regarding coccyx wound." The epidermal and dermal tissues were sharply debrided for a total square cm (centimeter) of 10. Devitalized and non viable lissue was removed to improve granulation tissue formation, stimulate wound healing, decrease overall bacteria load, disrupt biofilm formation and decrease edge senscence." Review of R43's, Order Summary Report, dated 4/2/15, identified a physician order, 'reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift." The form titled, Treatment Record, for June 2015 and July 2015, read, "Reposition every 2 hours when in bed and every 30 minutes when up in wheel chair every shift. Start date 4/2/15." Although the treatment record directed staff to reposition R43 every 30 minutes when up in the wheel chair, review of the nursing assistant care sheet dated, 6/30/15, read, "reposition every 2	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
HOUIS.	2 900	ask am staff tomorr Allevyn and Skin processary and Skin processary on 3/4/1 medication sheet is medial and inferior Apply every shift. The MAR on 3/4/15, 3-1 R43 was seen at the year of tissues were sharpled concessary wound." The tissues were sharpled concessed bacteria load decrease edge sense over all bacteria load decr	row to call for orders for the ep orders." lication Administration Record 6-3/31/15, begins to sign out der to (R) buttock (Superior ery 3 days and prn (whenever 5. The next direction on the for 4 layers skin prep to areas of shearing (R) buttock. his is first signed out on the 1 shift. e wound clinic on 4/2/15 at hysician note read, "[R43] is ascular Clinic today regarding e epidermal and dermal y debrided for a total square 10. Devitalized and non viable d to improve granulation tissue wound healing, decrease d, disrupt biofilm formation and scence." Inder Summary Report, dated only sician order, "reposition in bed and every 30 minutes hair every shift." attment Record, for June 2015 It, "Reposition every 2 hours ery 30 minutes when up in hift. Start date 4/2/15." Itent record directed staff to ry 30 minutes when up in the of the nursing assistant care				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		07/0	2/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
WOODL	YN HEIGHTS HEALTH	CARE CENTER	ER 55TH ST ROVE HEIGH	REET EAST TS, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
2 900	During an observat R43 was seated at was wearing grippe foot pedals on the voffered to stand or during the observat 6:00 p.m. During an observat until 7:30 a.m. R43 a table by the eleval wheeled to the dining a.m. R43 was wheeled to the dining a.m. R43, with 1 states to bed. When intervenursing assistant (N6:30 a.m. into the woffers to change poduring this two houst time. NA-A, acknow sheet did not specificant stated NA-A we been informed that change every 30 m validated R43 was position while seated when settled into be creases and crevice buttocks area from numerous red created to posterior thighs a incontinent of urine	ge 11 ion on 6/29/15, at 4:45 p.m., the dining room table. R43 or socks, and there were no wheel chair. R43 was not change position from the staff ion period from 4:45 p.m. until ion from 7/1/15 from 7:00 a.m. was seated in a wheel chair at tor. At 7:30 a.m. R43 was not room for breakfast. At 8:30 eled to the bedroom. At 8:40 aff assistance, was transferred viewed on 7/1/15, at 8:40 a.m., NA)-A, verified R43 was up at wheelchair and there were no sition or offload buttocks, and ten minute period of wledged the aide assignment for half hour position changes orked full time and had never R43 required a position inutes. Furthermore, NA-A not able to physically change ed. Observation of R43s' skin ed at 8:45 a.m., revealed red es to posterior thighs and the brief. NA-A verified the ses and crevices were present and buttocks. R43 was not at this time. LPN-A proceeded hange to the superior right	2 900				
	and documentation which read; "1.6 x 1 granulation tissue.	neasurements from 6/30/15 from the Skin/Wound note x 0.2 cm (centmeter) 100% No tunneling noted with gentle ed. Cleansed. Patted Dry. 2 x					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00829	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	2 gauze pad cut in acid. Placed in wou pad and secured w The largest measurarea were recorded 3/15/15, as 4.3 x 2. =/> [sic] 2.6 cm. Do notes indicated the buttock wounds hed decubitus was mealength x 1.0 width x The facility transition documented a visit Healtheast Medical 3/2/15, however, th buttock wound issured documented visits to 3/16/15, 3/20/15, 3/5 buttock wound issured with the chair and air During an interview (DON), registered in 7/2/15, at 10:00 a.n. information available inspections associated with the and if there was no other documentation other documentation.	half and moistened with acetic nd bed. Covered with ABD ith hypafix tape." rements for the right superior I in the progress notes 5 cm. (centimeter) Depth is reumentation in the progress right medial and right inferior aled 3/18/15. The superior sured on 6/30/15, as 1.6 .20 depth in centimeters. nal care physician to R43 on the form titled, Care for Seniors dated ere was no mention of any es. Furthermore the physician of R43 on 3/6/15, 3/9/15, 23/15 and did not address any es. On 3/27/15, the physician of skin involving buttock ff request referral to wound e. Additionally, load-off cushion mattress are to be obtained." with the director of nursing nurse (RN)-A and RN-C on n., there was no data or e indicating specific skin ted with bathday prior to the I discovery 3/1/15, because need in the computerized atement which read, "bruises" admission right arm fracture, skin issue, there would be no	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00829	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Skin and Positionin Defined Assessmer because the facility there were wounds Interview on 7/2/14 who worked full tim aware R43 was to h 30 minutes, while s assignment sheet of R43's position ever SUGGESTED MET The director of nurseducate nursing state care and supervision the resident's indiving The DON or design	g Evaluation UDA (User nt) was not used for R43 did not use the form until a according to the DON. At 11:00 a.m., with NA-B, e, also verified not being nave a position change every eated, and validated the aide lid not inform staff to change y half hour. CHOD OF CORRECTION: Sing (DON) or designee could aff regarding providing nursing on for residents according to dual needs and assessment. In the care to and report the findings to	2 900			
	days.	R CORRECTION: Thirty (21)				
2 915	Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's conditional comprehensional conditional comprehensional comprehension	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this ily living includes the	2 915			8/11/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00829	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	(2) transfer an (3) use the toil (4) eat; and (5) use speech	d ambulate;	2 915			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an ambulation program to improve or maintain a resident's ability to ambulate for 1 of 1 resident (R43) reviewed for ambulation. The failure of the facility to consistently implement an ambulation program resulted in harm for R43 who sustained decreased strength and inability to ambulate.			No POC required.		
	facility on 2/6/15,fol the right humerus (interagency transfe admission, R43 had the assisted living, A fourteen day mini assessment dated in the corridor durin period, and had wa A thirty day MDS danot walked in the had	itted from an assisted living lowing a fall and fracture of upper arm). According to r documentation at the time of d been ambulating 300 feet at according to the therapy goals. mum data set (MDS) 2/20/15, R43 had not walked go the seven day assessment liked in the bedroom only once. ated 3/6/15, indicated R43 had allway, but had walked in the ng the 7 day assessment				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00829	B. WING		07/0	02/2015
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPI	PER 55TH ST	REET EAST ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 915	titled, Physical Ther 2/6/15, included; "C narrow base quad of CGA (care giver as functioning Ambular quad cane on even assist secondary to balance). Goal date According to the PT been independently assisted living setting fracture secondary. R43 was discharge PT Discharge Sumprovided to some oprogram." The curridentified as; "Amburailing on even surfnursing staff trained FMP (full mobility patherapy "Goal" inclusing from the provided (1) in or either ALF (assisted nursing facility) setting observations 6/29/15, R43 was nencouragement to say and say was seated at gripper socks, with chair.	sical therapy documentation rapy (PT) Plan of Care, dated foal Ambulate 75 feet with cane on even surfaces with sistance). Current level of tes 35 feet with narrow base surfaces with MIN (minimum) occasional LOB (loss of a 3/31/15." T progress notes, R43 had ambulating 300 feet in the narrow base to a fall. If the nursing staff for gait rent level of function was callates 15 feet with L (left) hall aces with CGA, Some of the dring with patient for otential). "The physical called; "ambulate 300 feet with ad walker) with MOD reder to live independently in driving facility) or SNF (skilled ing." Is from 4:45 p.m 6:00 p.m.on ot offered assistance or stand or walk. At 5:15 p.m., the dining room table wearing no foot pedals on the wheel	2 915			
	7:30 a.m., R43 was table near the eleva	ion 7/1/15 from 7:00 a.m. untiles seated in a wheel chair by a lator. At 7:30 a.m. R43 was a room for breakfast. At 8:30				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.				
		00829	B. WING		07/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODLY	N HEIGHTS HEALTH	CARE CENTER	ER 55TH ST	REET EAST TS, MN 55077		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 915	Continued From pa	ge 16	2 915			
	a.m., R43 was whe 8:40 a.m. R43 was R43 was only able seconds before stathen assisted to trathen assistance of one so During the observathat R43 had been at 6:30 a.m. without encouragement/assistated R43 was not steps. NA-A stated on the unit, but had walk R43 since administration.	eled back to her bedroom. At observed during a transfer. to tolerate standing for 30 ting, "that's enough!" R43 was nsfer to her bed with the taff, nursing assistant (NA)-A. tion, NA-A verified at 8:40 a.m. transferred into the wheelchair t an sistance to ambulate. NA-A physically able to take any she herself worked full time not walked or attempted to nission/re-admission.				
	Family member (F)-A was present during the transfer 7/1/15, at 8:40 a.m., and acknowledged that staff did not ambulate R43. F-A stated, "They stopped walking her." F-A further stated R43 had been independent in the assisted living prior to the fractured right arm, and said she was afraid R43 would lose her ability to walk. During this conversation, R43 expressed a desire to be walked in hopes of returning to the assisted living.					
	NA-B, another full t	on 7/2/14, at 11:00 a.m., with ime staff, she stated she did suppposed to ambulate.				
	(LPN)-A on 7/2/15 a was aware R43 could know there was an At that time, register interviewed. RN-C who completed the stated R43 had been of 2 staff for walking	with licensed practical nurse at 11:30 a.m., she verified she ald take steps, but did not ambulation program for R43. ared nurse (RN)-C was stated she was the person MDS assessments. She an admitted as extensive assist g in the room, and verified R43 allway five of the seven				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			B. WING		07/0	0/0045
		00829			07/0	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE REET EAST		
WOODL	N HEIGHTS HEALTH	CARE CENTER		ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 17	2 915			
	observation days diperiod (ARD) of 2/1	uring an assessment review 7/15.				
	discharged to the h the humerus fractu from the hospital, th the 14 day MDS da MDS dated 4/12/15	eview revealed R43 had been ospital for surgical repair of re on 3/12/15. Upon return ne 5 day MDS dated 3/22/15, ted 3/29/15, and the 30 day is, all indicated there had been e bedroom or hallway during riods.				
	Data Set (MDS) da	of R43's quarterly Minimum ted 5/8/15, indentified R43 as th dependence on staff for ing (ADL).				
		ant care sheet dated 7/1/15, oulatory for in room and				
	physical therapy as possible the nursing completed and pas expressed training	on 7/2/15, at 1:12 p.m., the sistant (PTA) thought it was g referral sheet had not been sed on to the nurse. The PTA two nursing assistants to g the left arm and the handrail				
	expressed not know acknowledged the	on 7/2/15, at 1:20 p.m., RN-A wing R43 could walk and process had been "dropped" ad not received the rehab erapy department.				
		on was submitted by the of the facility, after survey, July				
	"R43's ability to am	bulate had been inconsistent				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

00829

NAME OF PROVIDER OR SUPPLIER

WOODLYN HEIGHTS HEALTHCARE CENTER

KIX1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:

B. WING

B. WING

O7/02/2015

STREET ADDRESS, CITY, STATE, ZIP CODE

2060 UPPER 55TH STREET EAST
INVER GROVE HEIGHTS MN 55077

NAIVIE OF I			STATE, ZIP CODE					
WOODLYN HEIGHTS HEALTHCARE CENTER 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
2 915	since her admission due to instability secondary to right humeral fracture, then due to surgical repair of the humeral fracture with restrictions of the RUE [right upper extremity] and then with a significant laceration to her LLE [left lower extremity] with edema." "Point of Care Documentation shows that R43 has never ambulated in the hallway since her admission. She has been inconsistent but does ambulate in her room with extensive assistance of one staff. She maintains her ability to participate consistently in her bed mobility. Upon discharge from physical therapy 4/10/2015 R43 did not achieve her goal of ambulation 50 feet with staff assistance but was ambulating a distance of 15 feet with contact guard assistance." "Resident R43 was referred to therapies on 7/7/2015 for gait training and to initiate a gait program. On 7/7/2015 Resident (R43) current level of function is noted that she ambulaters 15 feet on even surfaces with minimal assist using left handrail and right upper extremity supported on therapies arm. Resident's current level of function demonstrates that she continues to improve and did not have a loss of ability. A walking program has been put in place. R43 is currently receiving pain medication to promote mobility".	2 915						
	SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure activities of daily living is provided. The Director of Nursing Services or designee							

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00829	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 SHOUL CROSS-REFERENCED TO THE APPROFI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	and procedures. Th	opropriate staff on the policies are Director of Nursing Services develop monitoring systems to appliance.	2 915			
21426	Prevention And Cor (a) A nursing home maintain a comprehinfection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of leation, as published in CDC's ality Weekly Report (MMWR). Include a tuberculosis in that covers all paid and contractors, students, interest. The Department of extechnical assistance intation of the guidelines.	21426			8/11/15
	by: Based on documen facility did not provid	ent is not met as evidenced it review and interview, the de tuberculosis screening for E-A, E-B, E-C, E-E) and 2 of 5		No POC required.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00829	B. WING		07/0	2/2015
WOODLYN HEIGHTS HEALTHCARE CENTER 2060 UPPE		ER 55TH ST	REET EAST ITS, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	residents (R47, F11 screening. Findings include: Employee record re (E)-A, hired 5/18/15 symptom screening tuberculin skin testi E-B, hired 4/7/15, h skin testing documentation of a examination with th E-C, hired 2/19/15, dated 1/19/04, that Impression: Negati documentation of a examination with th E-E, hired 4/7/15, h 11/08/11, that read, MantouxFINDING disease " There is corresponding physichest x-ray. Review of R47's readmitted on 6/15/13 in the record for test tuberculosis infection admission in 2011. R115's record show and the only documentating for presence a one-step tuberculosis.	5) reviewed for tuberculosis eview revealed employee 5, did not have a completed g and had only one step of ng documented on 5/16/14. had only one step of tuberculine ented on 4/4/15. had a chest x-ray report, read, "Indication: +PPD. ive chest." There was no corresponding physical e chest x-ray. ad a chest x-ray report, dated "INDICATION: Positive as:Lungs are clear of active was no documentation of a sical examination with the cord showed the resident was and the only documentation on was from a previous yed she was admitted 4/4/15 tentation in the record for e of tuberculosis infection was in skin test dated 1/4/15. ulosis policy, dated 4/2/15,	21426			
	read, "Baseline TB	screening is required at the ealth care workers in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	TE SURVEY MPLETED	
	00829		B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Minnesota. Baselin assessing for curre disease, (2) assess for the presence of tuberculosis by adm tuberculin skin test testBaseline TB s required at time of a settings licensed as nursing homes. Ba (1) two-step TST or symptom screen, a patient's risk factors. When interviewed a surveyor requested from the director of she would look for in 7/7/15, at 2:10 p.m. that she could not led documentation at the looking. SUGGESTED MET The director of nursidevelop, review, an Control/tuberculosis	ne TB screening includes: (1) nt symptoms of active TB sing TB history, and (3) testing infection with Mycobacterium inistering either a two-step (TST) or single TB blood creening of patients is admission for health care is boarding care homes and iseline TB screening includes: single TB blood test, (2) TB and (3) assessment of the is for TB. In 7/2/15, at 9:30 a.m. the the missing documentation nursing and she stated that the director of nursing stated ocate any more his point, but would keep THOD OF CORRECTION: sing (DON) or designee could d/or revise Infection is program and ensure that uberculosis prevention are	21426			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21530	MN Rule 4658.1310	O A.B.C Drug Regimen Review	21530			8/11/15
	A. The drug regim	en of each resident must be				

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AND DI AN OF CODDECTION IDENTIFICATION NI IMPED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00829	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPF	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, MN 55077		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	reviewed at least m currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Mealth Care Finance This standard is in available through the system. It is not sure B. The pharma irregularities to the and the attending p must be acted upor physician visit, or support and the signiof nursing services C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely affer efer the matter to the attending physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter to the medical direct must refer the matter the ma	onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next coner, if indicated by the proses of this part, "acted coceptance or rejection of the ng or initialing by the director and the attending physician. In ing physician does not concurts recommendation, or does the justification, and the set the resident's quality of life is extend, the pharmacist must he medical director for review for is not the attending edical director determines that can does not have adequate order and if the attending change the order, the matter or review to the quality surrance committee required and the attending physician is or, the consulting pharmacist er directly to the quality surrance committee.	21530			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00829	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530	This MN Requirement by: Based on document facility's consulting facility of irregulariti specific target beha anti-anxiety medica	ge 23 ent is not met as evidenced at review and interview, the pharmacist did not advise the es regarding the lack of aviors related to the use of an tion for 1 of 5 residents (R1) essary medications.	21530	No POC required.		
	order for clonazepa milligram (mg) by m schizophrenia. The records for June, 20 R1 was currently re treatment administr and July, 2015 read (Clonazepam) agita of this behavior liste a target behavior rethe current plan of company with the current plan of company in the current p	aled a 5/12/15, physician's im (anti-anxiety medication) 1 mouth at bedtime for paranoid medication administration 215 and July, 2015, revealed ceiving this medication. The ation records for June, 2015 d, "Target Behavior #1-ation" There were no details ed. There was no reference to elated to clonazepam use on care for this resident. 2017/2/15, at 2:04 p.m. 2018/2/15, at 2:04 p.m. 2019/2/15, at 2:04 p.m.				
	dated 5/19 and 6/18 pharmacist had rev However, there wer recommendations f the lack of specific this resident.	ication Regimen Review form 3/15, revealed the consulting iewed R1's drug regimen.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00829	B. WING	·····	07/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
WOODLY	N HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, 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 APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21530	p.m. the facility's coasked if she looked with the use of psycreviewing resident in pharmacist replied specific target behaviors. The sum Consultant Pharma Nursing for this resincluded the recomspecific Target Behother psychoactive taking at that time. explained she had facility about this reconsultants for the	onsulting pharmacist was I for specific target behaviors choactive medications when records. The consulting that she did look for the aviors and made to use specific target veyor mentioned there was a ucist Communication to ident on 2/21/15, which mendation to use "patient aviors" for the use of several medications that R1 was The consulting pharmacist spoken with the staff at the quirement and the nurse facility stated were working on mentation of appropriate	21530			
21535	The pharmacist and in-service and mon maintaining a funct pharmaceuticals set TIME PERIOD FOR (21) days. MN Rule4658.1315 Drug Usage; General Subpart 1. General	ervices for the residents. R CORRECTION: Twenty One S Subp.1 ABCD Unnecessary ral al. A resident's drug regimen	21535			8/11/15
	unnecessary drug i	unnecessary drugs. An s any drug when used: dose, including duplicate drug e duration;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00829	B. WING		07/0	2/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WOODL	YN HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, 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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	C. without adea D. in the prese which indicate the or discontinued. In addition to the discontinued and the second reference of the discontinued and the standard is incomposed an	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lth and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not change. ent is not met as evidenced view and interview 2 of 10 medications reviewed did not specific target behaviors f the anti-anxiety medication and did not assure physician	21535	No POC required.		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED	
	/02/2015	
WOODLYN HEIGHTS HEALTHCARE CENTER 2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETE DATE	
target behavior related to clonazepam use on the current plan of care for this resident. When interviewed on 7/2/15, at 2:04 p.m. licensed practical nurse (LPN)-C, the nurse manager for this unit, was asked what specific behaviors R1 demonstrated with agitation. She replied R1 refused cares, could be delusional, and can't stop talking. R69's medical record lacked documentation ensuring adequate monitoring of medications. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for accuchecks, call MD (doctor of medicine) or NP (nurse practitioner) for blood glucose less than 75 or greater that 400. A review of R69's medication administration record (MAR) for June, 2015 indicated fifteen readings greater than 400 had been recorded. However, a review of progress notes for the month of June, 2015, lacked indication of MD or NP notification of blood glucose readings greater than 400. Review of R69's Medication Review Report dated 7/1/15, indicated a physician order for "Metoprolol Tartrate [medication for high blood pressure] 50 mg 8a and 8p hold for S8P [systolic blood pressure] less than 110." Review of R69's MAR for June, 2015 indicated on 6/26/15, R69's blood pressure was 109/76, and R69's medication was not held. There was no documentation the BP had been retaken and review of progress notes for June, 2015, lacked documentation regarding the low blood pressure or of any follow-up. When interviewed on 7/2/15, at 10:27 a.m., LPN-C verified the June, 2015, blood glucose		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING.			
		00829	B. WING		07/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODLY	/N HEIGHTS HEALTH	ICARE CENTER		REET EAST ITS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	nurse to call the MI greater than 400. I blood pressure reach the expectation was medication per parallow blood pressure SUGGESTED MET The director of nursin-service all staff re	O when the blood glucose was LPN-C also verified the low ding on 6/26/15, and indicated is for the nurse to hold the ameters, and follow up on the company of the company o	21535			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21545	A nursing home mu. A. Its medication percent as described Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long incorporated by refepurposes of this pa (1) a discrepant prescribed and what administered to result (2) the administered to result (2) the administered to result (3) the administered to result (4) an errorulation of discomfort or jeopa safety; or	of A.B.C Medication Errors ast ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For art, a medication error means: ancy between what was at medications are actually idents in the nursing home; or estration of expired any significant medication medication error is: which causes the resident ardizes the resident's health or	21545			8/11/15

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00829	B. WING	· · · · · · · · · · · · · · · · · · ·	07/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WOODLY	YN HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, MN 55077		
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21545	requires the medicate be titrated to a specimedication error con precipitate a reoccut toxicity. All medicate prescribed. An incomprescribed. An incomprescribed and the cocurs. Any significant or the physician or the phyresident or the resident or the resident or the resident prescribed. An incircipate and the cocurs. Any signification or the phyresident reactions or physician or the phyresident or the resident	ation in the resident's blood to cific blood level and a single buld alter that level and aurrence of symptoms or ions are administered as cident report or medication error gnificant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation are resident's clinical record. Ons are administered as dent report or medication error and for any medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation in the dent's legal guardian or entative and an explanation in the resident's clinical record.	21545			
	review the facility d medications were r	ion, interview and document id not ensure four expired emoved from storage for 2 of reviewed, potentially affecting 22, R40).		No POC required.		
	Findings include:					
	on 6/29/15, at 12:39 discovered: an ope R8, with an opened	cation cart for the 600 hallway, 5 p.m. the following were n bottle of Levemir insulin for l on date of 5/12/15, (48 days le of guaifenesin (cough				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	00829		B. WING		07/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/0	2/2013
WOODLY	WOODI YN HEIGHTS HEAI THCARE CENTER			REET EAST ITS, MN 55077		
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 29	21545			
	medicine), 200 milligram (mg) tablets for R22, with an unreadable direction label, and an expiration date of 3/15.					
	Registered nurse (RN)-B verified the medications were expired and should not be used, and the direction label on the bottle of guaifenesin was unreadable.					
	Review of the medication cart for the 500 hallway, on 6/29/15, at 12:53 p.m., the following were discovered: an open bottle of Lantus insulin for R40, with an opened on date of 5/22/15. (38 days prior.)					
		Nurse (LPN) - E verified the the insulin was expired and .				
	for Levemir solution	ord indicated a physician order n (Insulin Detemir) Inject 28 y every evening shift for				
		cord indicated a physician in tablet 400 mg tablet oral sary (prn.)				
	order for Lantus So	cord indicated a physician lution (Insulin Glargine) Inject sly one time a day related to				
	March 2015, indica expiration date of 3 procedure also indi	oiration Procedure dated ted insulin vials had an 0 days after opening. The cated medications would be date of expiration the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED	
		00829	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	nursing (DON) or d for all staff respons medication to reside following facility polensure medication occurring. The DON ensure medication occurring. Time Period for Control of the formula of the form	of Correction: The director of esignee could conduct training ible for administering ents to ensure staff are icies and procedures and expirations are not or designee could monitor to expiration dates are not	21545			
21695	Subp. 4. Houseke provide housekeep necessary to mainta comfortable interior ceilings, registers, f and furnishings. This MN Requirements:	eping. A nursing home must ing and maintenance services ain a clean, orderly, and including walls, floors, ixtures, equipment, lighting,	21695	No POC required		8/11/15
	review, the facility fa was free of odors a condition for 2 of 2 for room odors. Findings include: When interviewed of stated an odor was	on, interview and document ailed to ensure the bathroom nd kept in a cleanable residents (R65, R51) reviewed on 6/30/15, at 10:46 a.m. R65 noted in the bathroom, and "it there." At this time a stale ed in the bathroom.		No POC required.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00829	B. WING		07/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WOODLY	N HEIGHTS HEALTH	CARE CENTER		REET EAST TS, 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	R51 were noted to urine. The director of [DES] reported the chronic issue. The informed him they of the gentlemen in the when urinating. The be with the grout or time the backsplash away from the wall finding. The 7 Step Daily W dated 1/1/2000, dire Supplies.", "2. Emp 4. Clean and Sanitize and Sanitize the Co Walls and/or Partitic Floor." SUGGESTED MET Administrator or de system to ensure the comfortable, withour outine basis. The Accould develop a system to enducated director of facility of develop a monitoring compliance.	ge 31 a.m. the bathroom of R65 and have a strong odor of stale of environmental services odor from the bathroom was a DES stated housekeeping had clean the bathroom, and then e room miss the toilet bowl DES reported the issue may a the floor or the toilet. At this a against the sink was coming and the DES confirmed this ashroom Cleaning procedure, ected staff "1. Check ty Trash", 3. Dust Mop Floor", ze Sink and Tub", "5. Clean ommode.", "6. Spot Clean ons" and "7. Damp Mop THOD OF CORRECTION: The signee could develop a ne environment was clean, at odors and checked on a administrator or designee stem for staff to report any shysical plant. All facility staff on these systems. The perations or designee could no system to ensure ongoing arrection: Twenty-one (21)	21695			
21870	•	.651 Subd. 18 Patients & ac.Bill of Rights	21870			8/11/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY LETED	
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	WOODLYN HEIGHTS HEALTHCARE CENTER 2060 UP			STATE, ZIP CODE REET EAST ITS, MN 55077		
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21870	Subd. 18. Resporresidents shall have reasonable respons requests. This MN Requirements: Based on interview	nsive service. Patients and ethe right to a prompt and se to their questions and ent is not met as evidenced and document review, the	21870	No POC required.		
	council concerns rewhich had the potel reviewed; R77, R9 Findings include: Review of Resident Minutes, dated 4/21 "Long call light time shipment of radios process of marking distributed to staff" light wait times." Or Meeting Agenda an Business "Long cal "New shipment of raddressed in nurse and education of stand date included " situation and educator resolution. Addressed in nurse and education of stand date included " situation and educator resolution. Addressed in nurse and education and educator resolution. Addressed in nurse and date included " situation and educator resolution. Addressed in nurse resident satisfaction progress. The Resi and Minutes for 6/2 on call light wait times."	w up on family and resident garding call light wait times ntial to impact 6 of 6 residents, R11, R52, R115 and R64. Council Meeting Agenda and /15, revealed in new business " with an action plan "new was received, we are in the them and getting them This should help with the call of 5/19/15 the Resident Council d Minutes noted in Old I light time" with the action adios was received, will be and nurse's aide meetings, aff on spot audits." Resolution Ongoing monitoring of the tion of staff. Continuing date essed in meetings on 5/20 and did not include comments on with call light wait time dent Council Meeting Agenda 3/15, did not include follow up es, despite being noted as action and monitoring on the				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00829		B. WING		07/0	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODL	YN HEIGHTS HEALTH	CARE CENTER	ER 55TH ST ROVE HEIGH	REET EAST TS, MN 55077		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21870	O Continued From page 33		21870			
	"2. Nurses/aide relateamwork. They are they aren't on their Timely call light tim meal times. 4. Aide there an incentive faction Plan noted there to help, will contend the teamwork. Upcoming June. 3. Continuing Customer Service that helps with this radio system in place of the teamwork. There weekends. Encourate well as fill out a fee nurses if this occur. [evening/afternoon] purchased should here.	nutes, dated 5/21/15, revealed ationship-seems to be no en't responding to residents if wing or if it's not their job. 3. es, long call light time during s hide on the weekend, is or them to not do so?" The Customer Service rounds are ontinue to re-educate staff on a staff training scheduled for to work on this issue, again, rounds are being done and issue, and we have a new ce to communicate more is a Manager on Duty on the aged to speak with them, as dback form. Talk with the in the PM. New radio that were recently nelp as well." There were no ags for Family Townhall.				
	The facility failed to to call light wait time	follow up on concerns related es for R77.				
	A review of R77 annual MDS, dated 5/15/15 revealed R77 was cognitively intact and required extensive assistance for bed mobility, dressing, toilet use and personal hygiene and was totally dependent on staff for transfers. On 7/1/15 at 3:15 p.m. R77 reported he waited several minutes for assistance on a recent night to help move his legs back on the bed and to get a window closed when his room was cold. R77 reported he had spoke with the administrator, current and former director of nursing about call light wait times. On 7/2/15 at 10:05 a.m. R77 again confirmed he had recently waited a significant amount of time in pain for assistance					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00829	B. WING		07/0	2/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WOODLY	N HEIGHTS HEALTH	ICARE CENTER		REET EAST ITS, MN 55077		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
21870	Continued From pa	ge 34	21870			
	with getting his legs back on the bed, R77 reported call light concerns were a chronic issue with not enough done to resolve the issue.					
	revealed R77 waite assistance on the following of 6/21, morning of 6/21	t log for 6/21/15 to 6/27/15 d over a half hour for ollowing instances: morning of 22, twice on the morning of 26 and morning of 6/27.				
	The facility failed to follow up on call light wait time concerns for R9.					
	R9's most recent quarterly Minimum Data Set [MDS], dated 5/5/15 further confirmed R9 required staff assistance to meet basic needs including: extensive assistance required for bed mobility, transfer, locomotion on unit, dressing, toilet use and personal hygiene. R9's 5/5/15 quarterly MDS further revealed she was moderately cognitively impaired and was frequently incontinent of urine and bowel.					
	(F)-B, reported staff lights within a reason had observed R9 was reported "some aid to button calls." F-E brief because staff in a reasonable timbriefs. F-B reported problem may have with each other who staff may not have to alert them of call call light times occur.	p.m. a family member of R9, f were not responding to call chable time. F-B reported she wait over an hour for help. F-B es don't care and don't come B added R9 wore a disposable were not answering call lights e and R9 had waited in soiled B she believed part of the been staff not communicating en they went on breaks and worn the walkie system used lights. F-B reported extended arred on various shifts and had basis. F-B reported she various times.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMPI		
			7.1. 20122.110.1			
		00829	B. WING		07/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WOODLY	N HEIGHTS HEALTH	ICARE CENTER		REET EAST ITS, MN 55077		
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21870	Continued From pa	ge 35	21870			
	June 24th 2015 revexceeded thirty mir morning and aftern evening on 6/15, af 6/17, morning of 6/ morning of 6/24.	t times, for June 11th through realed R9's call light times nutes on the evening of 6/11, oon on 6/13, afternoon and ternoon of 6/16, morning of 18, afternoon of 6/18 and				
	The facility failed to times for R11.	follow up on call light wait				
	revealed he was co	annual MDS, dated 5/23/15, ognitively intact and required be for toileting and transferring.				
	waited over an hou	p.m. R11 reported he has r for assistance with assistance with toileting and R11 noted he was				
	R11's call light record for 6/21/15 to 6/27/15 was reviewed. R11 waited over 30 minutes on the following instances: the morning of 6/21/15, the afternoon of 6/24/15 and the morning and the afternoon of 6/27/15.					
	The facility failed to time concerns for F	follow up on call light wait 852.				
	she was cognitively	MDS, dated 4/10/15, revealed rintact. R52 required extensive eting and transferring.				
	see I shouldn't go to can't wait I have a I how long she waite	p.m., R52 reported "well you o the bathroom by myself, but I ittle bladder" and when asked d with her call light on, R52 mes it seems like forever."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		00829	B. WING		07/	02/2015
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPF	ER 55TH ST	REET EAST TS, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21870	Review of R52's ca 6/27/15, revealed the light times over 30 6/21/15 and the after Review of R115's indated 4/21/15, revealed to	Il light record for 6/21 to ne following instances of call minutes: the morning of pernoon of 6/27/15. In cost recent admission MDS, realed R115 had severe not and required extensive mobility, transfers, dressing, and hygiene. 7 a.m. a family member of red she had put her call light on the bathroom and sometimes for staff to help. all light record for 6/21 to re following wait times were re evenings of 6/21 and remoons of 6/22, 6/23 and remoons of 6/22, 6/23 and red worked on call light red worked on call light red worked on call light red call light wait times from red after surveyor brought the red call light wait times from after surveyor brought the resident council concerns the administrator reported				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OMPLETED	
		00829	B. WING		07/0	02/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WOODL	YN HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, MN 55077		
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21870	and administrator rehave closely monitor thave closely monitor thave closely monitor that the control of the co	ge 37 eported the facility should ored call lights until resolved. on 6/30/15, at 8:39 a.m. R64 intact, expressed frustration lent council meetings because, re how call lights are not being by fashion the facility failed to the residents concern. R64 the walkie talkies when they at the walkie talkies when they are not being gon the couches or playing to 5:00 a.m. and turning off the resident had informed a issues and knew call light scussed at several resident resid	21870			
21880	administrator or despolicies, provide ed resident grievance Assessment and Ascould do random at Time Period for Con	THOD OF CORRECTION: The signee could review or revise ucation for staff regarding process. The Quality ssurance (QAA) committee udits to ensure compliance. rrection:Twenty-one (21) days.	21880			8/11/15
21000	Residents of HC Fa Subd. 20. Grieval shall be encourage their stay in a facilit to understand and		21000			0/11/19

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (A. BUILDING:		E CONSTRUCTION		SURVEY PLETED	
		00829	B. WING		07/	02/2015
	PROVIDER OR SUPPLIER	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21880	residents may voice changes in policies and others of their cinterference, coerci including threat of cgrievance procedur well as addresses a Office of Health Fanursing home ombous Americans Act, sec posted in a conspice Every acute care residential program 253C.01, every non facility employing my provides outpatient have a written interest a minimum, sets followed; specifies followed; specifies for facility resor resident to have advocate; requires grievances; and program 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed to requirement for a wy procedure.	e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area adsman pursuant to the Older tion 307(a)(12) shall be allowed by the acility, every in as defined in section acute care facility, and every fore than two people that in mental health services shall areal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written by the solution of the grievance is not a Compliance by hospitals, as as defined in section hospital-based primary and outpatient surgery in 144.691 and compliance by the organizations with section to be compliance with the written internal grievance				
	This Min Requireme	ent is not met as evidenced				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 39	21880			
	facility failed to active	and document review, the vely resolve personal ed for 2 of 2 residents (R9, light wait times.		No POC required.		
	The facility failed to	resolve a grievance regarding expressed by R9's family.				
	(F)-B, reported staff lights within a reasor reported they had of for help, and stated don't come to butto disposable brief becanswering call lights had waited in soiled believed part of the not communicating went on breaks and walkie talk system ulights. F-B reported times, and on variou extended call light tat 9:08 a.m., F-B reconcerns about call conferences, had sand other staff about reported at one poin half for R9 to get as them and told them added "they tell us thappens, but nothin claim they have a sont working." F-B resorted they have a sont working."	p.m., a family member of R9, f were not responding to call phable period of time. F-B bserved R9 wait over an hour "some aides don't care and n calls." F-B added, R9 wore a cause staff were not is in a reasonable time and R9 briefs. F-B reported she problem may have been staff with each other when they a staff may not have worn the used to alert them of call visiting R9 daily, at various us shifts and had observed imes during visits. On 7/2/15, ported she had expressed light wait times at care poken with the administrator at call light concerns. F-B int, after waiting an hour and a sistance she "went off on that was not acceptable." F-B to tell them when this ing ever changes" and "they yestem, but I said clearly it is exported these concerns were a months ago and a facility it received.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00829	B. WING		07/0	2/2015
NAME OF P	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOODLY	N HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, 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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	revealed F-B had e waiting an unaccep response. The facil the nursing assistant distributing more porcall light alerts. How this measure had rethere was no monit facility was unable is monitoring. A review of call light revealed R9's call light revealed R9's call light revealed R9's call light minutes on the ever morning and aftern afternoon and ever afternoon of 6/16 a mornings of 6/17, 6. R9's most recent of [MDS] dated 5/5/15 assistance to meet extensive assistance transfer, locomotion and personal hygie further revealed R9 impaired, and was and bowel. The facility failed to to call light wait time. On 7/1/15, at 3:15 personal hygie further revealed R9 impaired, and was and bowel.	pack Form dated 5/11/15, expressed concerns about R9 table time for call light ity noted they had educated into and were working on present walkies to alert staff of ever, there was no indication esolved the grievance, as oring of the measure, as the coprovide documentation of the times, for June 11 - 24, 2015 ght times exceeded thirty ning of 6/11/15; on the ing of 6/15/15; on the ing of 6/15/15; on the ind 6/18/15; and on the ind 6/18/15. Juarterly Minimum Data Set in revealed R9 required staff basic needs including: the required for bed mobility, in on unit, dressing, toilet use the ine. R9's 5/5/15, quarterly MDS was moderately cognitively frequently incontinent of urine follow up on concerns related	21880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		00829	B. WING		07/0	2/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		-	
WOODLY	/N HEIGHTS HEALTH	CARE CENTER		REET EAST ITS, 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21880	Continued From pa	ge 41	21880				
	recently waited a signain for assistance the bed. R77 report chronic issue with rissue.	n. R77 again confirmed he had gnificant amount of time in with getting his legs back on ted call light concerns were a not enough done to resolve the					
	revealed R77 had e call light wait times over a weekend. Th distributing portable	ck form, dated 5/11/15, expressed concerns regarding being longer than acceptable ne facility noted they were walkie talkies to staff. No or follow up was documented.					
	revealed R77 waite assistance on the fo	light log dated 6/21 to 6/27/15, d over half an hour for ollowing dates: the mornings and 6/27; and twice on the and 6/23/15.					
	revealed R77 was of extensive assistance	nnual MDS, dated 5/15/15 cognitively intact and required se for bed mobility, dressing, hygiene, and was totally for transfers.					
	the facility was not response times as desk. The facility har response issues by The facility had investom the previous w	a.m. the administrator reported regularly checking call light she could not print it out at her ad worked on call light ordering new walkie talkies. estigated call light wait times yeek after surveyor brought the tention, but could not reach a					
	[DON] and adminis regular review of ca	a.m. the director of nursing trator reported there was no all light wait times, but the cussed at staff meetings and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		00829	B. WING		07/0	2/2015
	PROVIDER OR SUPPLIER YN HEIGHTS HEALTH	CARE CENTER 2060 UPP	ER 55TH ST	STATE, ZIP CODE REET EAST ITS, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21880	new walkie talkies hand administrator rehave closely monitors. SUGGESTED MET director of Social Secould make sure reto, acted upon and to the residents.	nad been ordered. The DON eported the facility should bred call lights until resolved.	21880			