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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6YKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00803

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245235**

2.STATE VENDOR OR MEDICAID NO.
(L2) **662675000**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODBURY HEALTH CARE CENTER**
(L4) **7012 LAKE ROAD**
(L5) **WOODBURY, MN** (L6) **55125**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2007**

6. DATE OF SURVEY **06/01/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **165** (L18)

13.Total Certified Beds **165** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	165			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 06/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/25/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/18/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
CMS Certification Number (CCN): 245235
October 18, 2017

Mr. Michael Karel, Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

Dear Mr. Karel:

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 May 15, 2017 the above facility is certified for or recommended for:

165 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 165 skilled nursing facility beds located in rooms .

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245235

October 6, 2017
By ePOC Only

Woodbury Health Care Center
Attn: Administrator
7012 Lake Road
Woodbury, MN 55125

Dear Administrator:

SUBJECT: SURVEY FINDINGS AND IMPOSITION/DISPOSITION OF REMEDIES
Cycle Start Date: March 31, 2017

SURVEY RESULTS
On March 28, 2017 and March 31, 2017, Life Safety Code (LSC) Surveys and Health Surveys were completed at Woodbury Health Care Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level E, cited as follows:

- F323 -- S/S: E -- 483.25(d)(1)(2)(n)(1)-(3) -- Free of Accident Hazards/Supervision/Devices
- F431 -- S/S: E -- 483.45(b)(2)(3)(g)(h) -- Drug Records, Label/Store Drugs & Biologicals
- K741 – S/S: E -- NFPA 101 Smoking Regulations

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the Minnesota Department Of Health notified you on April 19, 2017, of the imposition of the following remedies, as well as your appeal rights:

- State Monitoring effective April 24, 2017
- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 1, 2017

Based on the survey findings, the MDH notified you they were recommending that the CMS impose an additional remedy, as follows:

- Civil Money Penalty effective March 31, 2017

The authority for the imposition of remedies is contained in subsections §§1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

The MDH conducted revisits at your facility on May 1, 2017 and June 1, 2017, and found that your facility was in substantial compliance as of May 15, 2017. As a result of these survey findings, the following remedies will not go into effect:

- Mandatory denial of payment for new Medicare and Medicaid admissions, which was to be effective July 1, 2017, will not be imposed
- Mandatory termination of your Medicare and Medicaid provider agreements, which was to be effective October 1, 2017, will not be imposed
- Federal Civil Money Penalty, will not be imposed

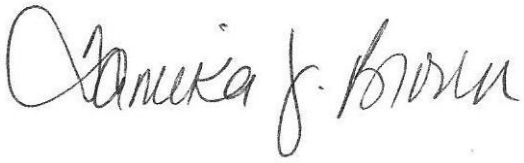
However, based on the period of time your facility was not in substantial compliance, the following remedy has gone into effect:

- State Monitoring was effective April 24, 2017 is discontinued effective May 15, 2017

INFORMAL DISPUTE RESOLUTION
You were previously advised by the MDH of the results of the informal dispute resolution (IDR) process. We have considered the IDR results in determining appropriate enforcement actions.

CONTACT INFORMATION
If you have any questions regarding this matter, please contact Tamika J. Brown, Principal Program Representative, at (312) 353-1502 or Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Health Insurance Specialist, at (312) 353-5169. Information may also be faxed to (443) 380-6614.

Sincerely,



Tamika J. Brown
Principal Program Representative
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245235
August 2, 2017

Mr. Michael Karel, Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

Dear Mr. Karel:

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 May 15, 2017 the above facility is certified for or recommended for:

165 Skilled Nursing Facility/Nursing Facility Beds

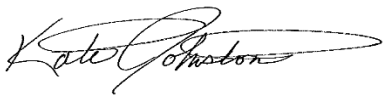
Your facility's Medicare approved area consists of all 165 skilled nursing facility beds located in rooms .

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

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

Please contact me if you have any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6YKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00803

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(L1) **245235**

2.STATE VENDOR OR MEDICAID NO.
(L2) **662675000**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOODBURY HEALTH CARE CENTER**
(L4) **7012 LAKE ROAD**
(L5) **WOODBURY, MN** (L6) **55125**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2007**

6. DATE OF SURVEY **03/31/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

12.Total Facility Beds **165** (L18)

13.Total Certified Beds **165** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	165			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Michelle Torrance, HFE NE II — 05/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/17/2017 (L20)

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

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

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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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06/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/18/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 19 2017

Mr. Michael Karel, Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

RE: Project Numbers S5235028, H5235080

Dear Mr. Karel:

On March 31, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed. In addition, at the time of the March 31, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5235080 that was found to be unsubstantiated.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793 Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective April 24, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 remedy be imposed:

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

Failure to submit an acceptable PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 July 1, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted March 27, 28, 29, 30, and 31, 2017. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. At the time of the survey, an investigation of complaint #H5235080 was completed and found to be unsubstantiated.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide service in a manner which promoted dignity for 2 of 2 residents (R123, R214), reviewed for dignity. Findings include: During an observation on 3/20/17, at 7:00 p.m. R123 was transferred into bed by nursing assistant (NA)-A and NA-B who failed to explain	F 241	It is the policy of Woodbury Health Care Center (WHHC) to promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. Plan of correction for residents cited with this survey: R123 was interviewed by the RN manager	5/15/17

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

Electronically Signed | 04/28/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. BUILDING _____ B. WING _____	C 03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY HEALTH CARE CENTER	7012 LAKE ROAD WOODBURY, MN 55125

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F 241	Continued From page 1 to R123 what they were going to do or how the transfer should go. R123 was only able to bear weight on the right foot due to left below the knee amputation and required the assistance of two staff with transfers. Once R123 was in the bed, NA-B told NA-A, [R123] liked to sleep in clothes, but R123 spoke up and said, "I don't want to sleep in my clothes, I want my pajama bottoms." NA-B then left the room in search of a basin to provide cares while NA-A searched the drawers for pajama bottoms. R123 was incontinent of urine in the brief. During cares NA-A and NA-B initially failed to notice the pressure ulcer on the sacrum when R123 turned to the side position in bed. Both expressed surprise upon seeing the pressure ulcer. When interviewed during cares on 3/27/17, at 7:15 p.m. NA-A and NA-B verified neither had performed any cares or offered cares for R123 since coming on the evening shift, because they thought R123 took care of self. NA-A and NA-B verified they did not know R123 had a pressure ulcer on the sacrum but they would call and inform the nurse. Document review of the form titled, Nursing Assistant Care Plan, updated 3/27/17, indicated R123 required assist of 2 staff for transfers and to be repositioned every 2 hours. There was no mention that R123 had a pressure ulcer on the sacrum. NA-A and NA-B left R123 naked in the bed for 8 minutes while waiting for the nurse to come and check the pressure ulcer. R123 was trying to pull the covers up so would not be naked waiting for the nurse.	F 241	to ensure that care is provided per the resident's instruction, choice and individual preferences with dignity and respect. R123's plan of care was updated per resident's interview directives and assessed needs. The care plan changes were communicated to staff. R214s Nursing Assistant Care Plan was updated to denote that the resident is to wear a camisole or undershirt as an undergarment daily to ensure that the resident does not expose herself to the public. The care plan changes were communicated to staff. Plan to address/prevent this deficiency for other residents: The Standards of Care Guidelines were revised to include dignity with dressing. The policy for Resident Rights were reviewed and remains current. Staff were re-educated on both policies. Measures put in place to prevent recurrence: Weekly dignity audits of 10% of the residents will be conducted x3 months to ensure that residents are being cared for with dignity, respect and per their wishes. Audit finding will be reviewed at monthly QAPI meeting with audits continuing if warranted. The Medical Director will review the new policy to ensure that current standards of practice are in place. Plan to Monitor: Weekly dignity audits of 10% of the residents x3 months will be conducted. Monthly review of audit findings at QAPI meetings with audits continuing as warranted. Mandatory resident rights	

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F 241	Continued From page 2 When interviewed on 3/29/17, at 2:41 p.m. about how it made R123 feel when the staff left the resident naked in the bed waiting for the nurse to come and look at the wound, R123 verified did not like being in a place where staff don't cover up "privates" because they are providing care and it is something that was hard to adjust to. R123 stated "I don't like it at all but that is the way it seems to be." Again asked R123 how does it make you feel and R123 stated, "irritable." Furthermore, R123 stated, "It makes me want to refuse care because I do not want to be uncovered sometimes." When interviewed on 3/30/17, at 11:53 a.m. R123 expressed concern that [R123] cannot always understand the staff, if they don't speak clear then it is frustrating, and if they keep asking to repeat because [R123] has a soft voice, indicated due to the frustration [R123] stated, "I will shut down the staff and not trust they can take care of me." In general, R123 confirmed would prefer modesty over exposure, but in the health care setting R123 was not aware of what could be said for respect and dignity. Now with the wound on the coccyx, R123 would prefer the staff respect privacy and follow through with not exposing "privates" they don't need to expose, for example to cover the body as much as possible when staff provide cares, for dignity. The facility did not have a policy for dignity and modesty but when interviewed on 3/30/17, at 2:00 p.m., RN-A verified the resident rights would be honored and it was the facility responsibility to know what residents preferred.	F 241	training upon new hire and annually. Responsible for maintaining compliance: RN Managers, Staff Development Director and DON	

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F 241	Continued From page 3 The facility failed to ensure R214 was dressed in a manner to ensure dignity. R214's quarterly Minimum Data Set (MDS), dated 3/8/16 revealed R214 had both short and long term memory problems, severely impaired cognitive skills for decision making and was unable to recall basic information about living situation. R214 required extensive assistance of two or more staff to dress. R214's Medication Review Report, dated 2/24/17, revealed diagnoses including Alzheimer's Disease with Early Onset and Anxiety Disorder, Unspecified. R214's Care Plan, last revised, 3/20/17, directed staff "Dressing: requires extensive assist of up to 2 staff. Make consistent dressing/grooming routine to provide a structured program to decrease confusion. Wears camisole under shirt Q [every] day." R214's Nursing Assistant Care Plan, updated 3/30/17, directed staff R214 required assistance of 1 staff for dressing. No notation was made regarding undergarments. On 3/29/17, at 7:34 a.m. R214 was observed lifting her shirt twice to wipe her mouth while sitting in the lounge area. R214's entire breasts were exposed as she lifted her shirt up. No undergarments were visible under her shirt. Several other residents, staff, and visitors were in the area. R214 was then taken by staff to the dining room. On 3/30/17, between 9:13 a.m. and 9:22 a.m. R214 was observed lifting her shirt and exposing	F 241		

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entire breasts, twice in the lounge area. No undergarments were visible. Multiple visitors, staff, and other residents were in the area. At 9:22 a.m., R214 propelled using wheelchair to the hallway and exposed entire breasts, three times while lifting shirt to wipe mouth. Multiple staff, visitors, and other residents passed by in the hallway, or were in nearby rooms. The dementia care manager led a tour group down the hallway past R214. R214 was noted licking her fingers and touching her clothes and objects in the hallway including the medication cart and hand rails. R214's pants and shirt had white soiled marks on them. At 9:28 a.m., RN-F walked into hallway and observed R214 exposing her breasts by lifting her shirt to wipe her mouth. RN-F said "oh" in a surprised tone of voice and brought R214 to her room. RN-F first looked in R214's dresser drawers and then in her closet and changed R214's shirt and put a fitted t-shirt under her shirt. NA-F entered the room and RN-F instructed NA-F that R214 should be dressed in an undergarment under her shirt every day. NA-F reported he could not find one when he dressed R214 earlier this morning and RN-F replied that one was found in R214's closet. NA-F reported being unaware R214 needed an undergarment underneath her shirt.

On 3/30/17, at 10:31 a.m. the nurse manager, RN-G reported staff should speak to the nurse about any concerns related to not finding clothing, to problem solve, look in laundry, or ask a manager to help check in laundry.

The Standards of Care Guidelines, revised 3/24/15, directed staff, "Woodbury Health Care Center staff will care for residents in a manner that promotes maintenance or enhancement of

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F 241	Continued From page 5 each resident's quality of life." and "Be sure undershirts, bras, slips, shorts or underwear are on appropriately."	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 272		5/15/17

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F 272	Continued From page 6 assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess pressure ulcers for 2 of 3 residents (R191, R48) with identified pressure ulcers; and failed to complete an accurate and comprehensive smoking assessment regarding safety for 1 of 1 resident (R50) in the sample observed smoking. Findings include: On 3/29/17, at 10:09 a.m. during observation of wound care for R191, licensed practical nurse (LPN)-A stated the thigh wound was looking worse today and there was now a reopened area in the coccyx. LPN-A stated the size of the coccyx open area fluctuated in size. LPN-A stated she had last seen the open areas on 3/27/17, when the dressing change to the coccyx open area was last completed. LPN-A stated she would have registered nurse (RN)-D assess the back thigh wound. Nursing assistant (NA)-E stated she had reported to the nurse yesterday (3/28/17) about the reopening of the area on the back of the left	F 272	It is the policy of WHCC to conduct a comprehensive assessment of each resident's skin condition within 24 hours of admission, upon identification of a new pressure injury and at least annually. It is the policy of WHCC to complete an accurate and comprehensive smoking assessment prior to permitting residents to smoke, upon change in resident condition and reviewed quarterly at their care conferences to ensure their safety. Plan of correction for residents cited in this survey: A new comprehensive skin assessment was completed for R191 and for R48. Care plan revisions were made as needed for R191 and for R48 and communicated to staff. An accurate and comprehensive smoking assessment was completed for R50 with care plan review, revisions made as needed and staff updated. Plan to address/prevent this deficiency for other residents:	

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F 272	Continued From page 7 thigh. However, the open area on the back of the left thigh was not assessed in a timely manner. A review of Progress Notes dated 3/28-3/29/17, revealed no assessment of the open area on the back of R191's thigh, near the gluteal fold, had been completed when it reopened. A Wound Summary documented indicated that on 3/8/17 and 3/17/17, the back of the left thigh was noted to be partial thickness, the tissue was bright pink/red, there was scant bloody drainage and the area measured 3 centimeters (cm), by 1 cm, with no depth. The Wound Summary document indicated that on 3/23/17, there was no draining and the area was superficial and had the same measurements as noted on previous dates. On 3/31/17, at 8:42 a.m. registered nurse (RN)-D stated she was aware of the open area on the back of R191's thigh on 3/29/17, but had been too busy to observe or assess the open area on 3/29/17. RN-D thought maybe LPN-A had made a notation about the measurements. A review of the progress notes by RN-D and the surveyor at this time revealed LPN-A had noted dressing changes were done on 3/29/17, but there was no documentation regarding the back of the left thigh having worsened in appearance. RN-D stated it was felt that prior to 3/30/17, the area on the back of the left thigh was from excoriation, due to pulling an incontinent product up between R191's legs. However, at 8:52 a.m. RN-D stated she had determined on 3/30/17, the back of the left thigh was now a Stage 2 pressure ulcer measuring 4.5 cm by 1 cm and was 0.2 cm in depth. R48 was admitted to the facility on 11/30/16, with hospital discharge physician orders for Duoderm	F 272	An audit of 100% of the residents with pressure injuries was completed to ensure that a comprehensive skin assessment has been done. Comprehensive skin assessments are in lace for all residents with a pressure injury. Comprehensive skin assessments will be initiated upon identification of a new pressure injury and at least annually. An audit of 100% of those residents that smoke was conducted to ensure that a comprehensive smoking assessment is in place. Comprehensive smoking assessments are in place for all residents that smoke. WHCC is not admitting new residents that smoke. The current residents that smoke will be reassessed upon change in condition and at least annually. Measures put on place to prevent recurrence: The policy and procedure for conducting a comprehensive skin assessment and/or comprehensive smoking assessment was reviewed and is current. Nursing staff will be re-educated on the comprehensive skin assessment and comprehensive smoking assessment policy and procedure. New skin conditions will be reviewed daily at stand-up and weekly with wound rounds to ensure that all requirements for assessment and management of pressure injuries are met. Plan to monitor: The RN Managers will audit all new admissions to ensure timely and accurate completion of the comprehensive skin	

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F 272	Continued From page 8 or similar to an open area on the coccyx. A review of nursing admission progress notes dated 11/30/16, and Nursing Admission Screening History dated 11/30/16, revealed the open area on the coccyx was not assessed. The Nursing Admission Screening History document indicated there was a pressure ulcer on the coccyx, but no other assessment of the area was documented on the form. A review of Physician's Order sheets indicated that on 12/5/16, the Duoderm to the coccyx was discontinued, as the open area had resolved. However, a physician's order dated 12/17/16, revealed either a new open area had developed on the coccyx or the previous area had reopened, as the physician ordered a new treatment of wound cleanser, calcine, non-stick pad and cover with Opsite to the coccyx. A review of Progress Notes dated 12/5/16-1/5/17 revealed there was no comprehensive assessment done of the new open area on the coccyx. On 12/21/16, LPN-A documented R48 had a pressure ulcer that was being treated with non-surgical dressing changes and ointments/cream/medications. However, there was no documentation in the progress note indicating where the pressure ulcer was located or the size of the open area. A comprehensive pressure ulcer assessment of the open area on the coccyx was not completed until 1/6/17. According to a document titled Wound Summary, a Stage 3 pressure ulcer was noted on R48's coccyx, which measured 3 centimeters (cm) long, by 1.5 cm wide and 0.60 cm deep.	F 272	assessment. Upon notification of a new pressure injury, the RN Manager will add the resident to weekly wound rounds to assure continued monitoring of the pressure injury with revisions to the treatment plan are made as warranted and that the comprehensive skin assessment has been completed. A review of root cause for new pressure injuries will be done weekly at the RN Managers meeting. All comprehensive skin and smoking audits will be reviewed at QAPI monthly. Responsible for maintaining compliance: RN Managers and DON	

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F 272	Continued From page 9 On 3/28/17, at 12:42 p.m. RN-E stated she was unable to find anything in the "Wound Rounds" computer program regarding pressure ulcers at the time of R48's admission to the facility or prior to the assessment dated 1/6/17. On 3/30/17, RN-E again stated she was unable to find an admission comprehensive pressure ulcer assessment for R48. RN-E verified the Nursing Admission Screening History completed on 11/30/16, was not a complete assessment and did not include measurements of the open area on the coccyx. The facility's 9/10, policy titled Guidelines for Pressure Ulcer Prevention Guidelines, indicated an assessment was required at the new onset of a clinical condition and development of a new skin risk factor. The steps for assessment included: review of the medical record, including skin care flow sheets and other skin tracking forms; speak with direct care staff and the treatment nurse to confirm conclusions from the medical record; assess the resident and determine if any ulcers were present on admission and readmission; determine the onset of pressure ulcers, by inspecting body prominences/full body audit; measure and record the pressure ulcers; identify any know or likely unstageable ulcers and determine the greatest tissue type severity. The facility did not complete an accurate and comprehensive smoking assessment regarding safety for R50, who was observed smoking. On 3/28/17, at 9:54 a.m. R50 was smoking with the supervision of nursing assistant (NA)-G in the outdoor designated smoking area for residents,	F 272		

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that was located immediately outside the lower level south exit of the facility. The facility's oxygen supplier was parked within 20 feet of this exit and actively filling oxygen tanks at that location. Immediately inside the door of this exit were 8 large oxygen tanks, temporarily stored until distributed to other areas of the building.

The smoking area was furnished with two benches, two smokers' posts, and a sign on a building post that read, "Designated Smoking Area." The administrator and engineering director were touring near the exit with a state fire marshal (FM)-D. When FM-D commented on the safety risk of the situation the administrator and engineering director assisted NA-G in moving the smoking residents farther away from the building. At 10:07 a.m. on the same date, this facility staff moved the benches and smoking pots out of this designated smoking area to another side of the building and removed the "Designated Smoking Area" sign.

R50's record contained a Smoking Safety Screen form, dated 3/16/17, that showed R50 required supervision for smoking due to cognitive deficits and would "be unsafe to be consistent with decisions regarding smoking." This form also described the resident as smoking morning, afternoon, and evenings, taking 5-10 cigarettes per day. The safety risk of the facility's designated smoking area was not identified on this assessment. This resident's current care plan, dated 1/29/17, contained a Focus for smoking risk that included an intervention that read, "Staff are to escort [R50] to designated smoking area as time allows and supervise smoking/safety."

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F 272	Continued From page 11 On 3/28/17 at 9:55 a.m. NA-G was asked if the designated smoking area that she brought residents to smoke on that date was the area that she always brought residents to smoke, and she replied that it was. On 3/30/17 at 2:58 p.m. the facility's corporate consultant was asked where and why the designated smoking area had been relocated. She replied that the designated smoking area had been moved to another side of the building and had been moved because the fire marshal approached the facility administrator with concern regarding the proximity of the original designated smoking area to the facility's area for oxygen filling and delivery. The facility's smoking policy, dated 1/28/17, read, " All residents requesting to smoke will be assessed for independent and supervised/assisted smoking status using the "Smoking Safety Screen" assessment form...Residents requiring supervision must agree to: ...c. smoking only in designated areas. d. scheduled smoking opportunities to be included in their care plan.	F 272		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request	F 280		5/15/17

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F 280	Continued From page 12 revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 280		

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WOODBURY HEALTH CARE CENTER	**7012 LAKE ROAD WOODBURY, MN 55125**

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F 280	Continued From page 13 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 4 residents (R191) who were identified by the facility as being incontinent of urine. Findings include: R191's care plan revised on 7/22/15, revealed R191 had functional bladder incontinence and	F 280	It is the policy of WHCC that care plans remain current and up to date to reflect the care and services provided to our residents. Plan of correction for residents cited in this survey: R191 had their care plan updated to reflect the care and services provided to	

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F 280	Continued From page 14 was to use a bed pan during Customer Service Rounds. The care plan directed staff to place on bedpan, reposition, and check for urinary incontinence at least every two hours. The care plan indicated R191 did not use the toilet per her preference. On 3/29/17, at 1:25 p.m. R191 was transferred from the wheelchair to the bed via a mechanical lift and assistance from two nursing assistants. R191's incontinent brief was removed and without using a bed pan, incontinence care was provided and a new incontinent brief applied. On 3/30/17, at 10:15 a.m. recreational therapist (RT)-A was asked if there was a bed pan in R191's room. RT-A searched R191's room and stated "I don't see one." Also at this time, R191, stated she did not use a bed pan. On 3/30/17, at 10:20 a.m. NA-G stated R191 did not use a bed pan and used an incontinent brief.	F 280	attain or maintain the highest level of practicable function. Plan to address/prevent this deficiency for other residents: All resident with urinary incontinence had their care plans reviewed and updated as needed to ensure compliance. Measures put into place to prevent recurrence: The policy and procedure for revising the care plan was reviewed and remains current. Staff have been educated on the policy and procedure. Plant to monitor: A random 5% audit of resident with incontinence care plans will be conducted x3 to ensure compliance. Audit findings will be reviewed at the monthly QAPI meetings. Audits will continue as warranted. Responsible for maintaining compliance: RN Mangers and DON	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		5/15/17

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F 282	Continued From page 15 by: Based on observation, interview, and document review, the facility failed to implement the care plan for 2 of 3 residents (R191, R123) with identified pressure ulcers; failed to follow the care plan for 2 of 4 residents (R191, R123) identified as incontinent of urine; and failed to follow the care plan for 1 of 2 residents (R214) dependent on staff for dressing. Findings include: R191's care plan was not followed in order to prevent/minimize pressure ulcers and to restore as much bladder function as possible. R191's revised care plan dated 3/23/17, indicated R191 had a new skin breakdown on the left thigh and was to be turned and repositioned at least every hour or more often as requested; and the care plan revised on 7/22/15, revealed R191 had functional bladder incontinence and was to use a bed pan during Customer Service Rounds. The care plan directed staff to place R191 on a bedpan, for urinary incontinence at least every two hours. The care plan indicated R191 did not use the toilet per her preference. . On 3/29/17, at 11:15 a.m. R191 was observed sitting in a wheelchair by the nursing offices. R191 remained in this area until 11:54 a.m. when the resident was taken outside to smoke. At 12:26 p.m. R191 was back on the unit and in her room. At this time R191 was asked when she had last been repositioned. R191, who was assessed as cognitively intact by the facility on 12/29/16, stated she had not been repositioned since getting up that morning. At 12:51 p.m. R191 received lunch in her room. At 1:04 p.m. a	F 282	It is the policy of WHCC that care plans remain current and up to date and are followed to reflect the care and services to our residents. Plan of correction for residents cited in this survey: R191 and R123 had their care plan reviewed for appropriate care and treatment of pressure ulcers and incontinence with updates and revision made if deemed necessary to reflect the care and services provided. R214 had their care plan reviewed with updates and revisions made if deemed necessary to reflect dependence on staff for dressing and the care and services provided. Plan to address/prevent this deficiency for other residents: All residents with pressure ulcers, those with incontinence and those residents dependent in dressing had a care plan review with updates and revisions made as needed to reflect the care and services provided. Measures put into place to prevent recurrence: The policy and procedure for the comprehensive care plan has been revised and remains current. Staff have been educated on the policy and procedure. Plan to monitor: A random audit of 5% of resident care plans with pressure ulcers, urine	

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F 282	Continued From page 16 nursing assistant went into the room to speak with the resident, but the resident, who was a two person transfer with a mechanical lift, was not repositioned. At 1:11 p.m. a nursing assistant entered R191's room and removed the lunch tray. R191 was not repositioned. At 1:21 p.m. R191 was asked if she wanted to go to bed and she stated she would. At 1:25 p.m. (which was 3 hours and 10 minutes without being repositioned or checked for urinary incontinence) R191 was transferred back into bed via a mechanical lift and the assistance of nursing assistants (NA) D and NA-E. A review of an undated Nursing Assistant Care Plan indicated R191 was to be repositioned every hour; was to be offered the bed pan with rounds and checked for urinary incontinence every two hours. During interview on 3/29/17, at 11:31 a.m. nursing assistant (NA)-E stated R191 was to be turned and repositioned every two hours. On 3/30/17, at 10:15 a.m. recreational therapist (RT)-A was asked if there was a bed pan in R191's room. RT-A searched R191's room and stated "I don't see one." Also at this time, R191, stated she was not using a bed pan. On 3/30/17, at 10:20 a.m. NA-G stated R191 did not use a bed pan and wore an incontinent brief. The facility failed to provide services in accordance with the written plan of care for R123, who required assistance with grooming, repositioning/pressure ulcer care, and incontinence care.	F 282	incontinence and dependence in dressing will be conducted monthly x3 to ensure compliance. The audit findings will be reviewed monthly at QAPI meetings. Audits will continue if deemed necessary. Responsible for maintaining compliance: RN Managers and DON	

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R123 was admitted to the facility on 3/16/17, and had a document titled, Individual Temporary Care Plan, initiated on 3/17/17.

Document review of the care plan for grooming revealed R123 was assist of 1.

During an observation of evening cares on 3/27/17 at 7:00 p.m. R123 was observed with long fingernails, jagged and broken on both hands, and long and jagged toenails on the right foot. R123 had an amputated left foot. R128 verified being a diabetic and had been told the nurse would have to trim the nails.

Document review of the facility form titled, Treatment Administration Record (TAR) dated 3/1/17 - 3-31-17, indicated Diabetic Nail Care: Assess feet weekly on bath day for skin integrity, CMS [color, motion and sensitivity] complete finger and toe nail care every day shift every Friday. The March 17, and March 24, 2017 Fridays were blank indicating the treatment was not performed by the nurse.

Document review of the care plan for repositioning revealed R123 required repositioning every two hours, one staff assist with physical transfer, and one staff to assist with equipment, clothing, etc.

Document review of the care plan for Bowel and Bladder revealed R123 was incontinent and required staff assistance.

When interviewed during cares on 3/27/17, at 7:15 p.m. NA-A and NA-B verified neither had performed any cares or offered cares for R123 since coming on the evening shift, because they

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F 282	Continued From page 18	F 282		

thought R123 took care of self. NA-A and NA-B verified they did not know R123 had a pressure ulcer on the sacrum but they would call and inform the nurse. Furthermore, NA-A and NA-B verified no offers to toilet R123 were offered on their shift because they thought R123 was continent of urine.

The facility failed to ensure the care plan was followed for dressing for R214.

R214's Care Plan, last revised, 3/20/17, directed staff "Dressing: requires extensive assist of up to 2 staff. Make consistent dressing/grooming routine to provide a structured program to decrease confusion. Wears camisole under shirt Q [every] day."

R214's Nursing Assistant Care Plan, updated 3/30/17, directed staff R214 required assistance of 1 staff for dressing. No notation was made regarding undergarments.

On 3/29/17 at 7:34 a.m. R214 was observed lifting her shirt twice to wipe her mouth while sitting in the lounge area, exposing R214's breasts. R214 was not wearing undergarments as directed.

On 3/30/17 between 9:13 a.m. and 9:22 a.m., R214 was observed lifting shirt, exposing breasts, twice in the lounge area. No undergarments were visible. At 9:22 a.m., R214 propelled self using wheelchair to the hallway and exposed breasts three times while lifting shirt to wipe mouth. At 9:28 a.m. RN-F walked into hallway and observed R214 exposing breasts by lifting shirt to wipe mouth. RN-F said "oh" in a surprised tone of voice and brought R214 to her

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F 282	Continued From page 19 room. RN-F first looked in R214's drawers and then in the closet and changed R214's shirt and put a fitted t-shirt under the shirt. NA-F entered the room and RN-F instructed NA-F that R214 should be dressed in an undergarment under her shirt every day. NA-F reported he could not find one when dressing R214 in the morning and RN-F replied that one was found in the closet. NA-F explained being unaware that R214 lifted shirt and that R214 should have an undergarment underneath the shirt.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide diabetic nail care, incontinent care, and assistance with dressing for 3 of 4 residents (R123, R191, R214) in the sample who were dependent upon staff for personal cares. Findings include: During an observation with evening cares on 3/27/17, at 7:00 p.m. R123 was observed with long fingernails, jagged and broken on both hands, and long and jagged toenails on the right foot. R123 had an amputated left foot. R128 verified being a diabetic and had been told the nurse would have to trim the nails. Document review of the facility form titled,	F 312	It is the policy of WHCC to deliver care and services to maintain good nutrition, grooming and personal and oral hygiene. Plan of correction for residents cited in this survey: Upon notification of these findings, R123 had diabetic nail care provided; R191 as directed by the surveyor, had incontinent care provided which included total perineal care and R214 was assisted to put an undergarment on under her shirt. Plan to address/prevent this deficiency with other residents: All diabetic residents had nails inspected and nail care provided as needed. Education was provided to staff on	5/15/17

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F 312	Continued From page 20 Treatment Administration Record (TAR) dated 3/1/17 - 3-31-17, indicated Diabetic Nail Care: Assess feet weekly on bath day for skin integrity, CMS [color, motion and sensitivity] complete finger and toe nail care every day shift every Friday. Review of the March 17, and March 24, 2017 sheets for Fridays were left blank, indicating the treatment had not been performed. Document review of the facility form titled, Nursing Admission Screening History dated, 3/16/17, did not address an assessment of the toenails or fingernails. When interviewed on 3/30/17, at 2:00 p.m. RN-A verified the nurse should have performed the nail care and signed off on the TAR per facility policy. R191 was not provided with the appropriate incontinence care after an episode of urinary incontinence. On 3/29/17, at 1:25 p.m. R191 was transferred from the wheelchair to the bed via a mechanical lift and assistance from two nursing assistants. R191's incontinence brief was removed. The incontinence brief was noted to be saturated with urine, and the condition of the brief was verified at the time by nursing assistant (NA)-D. After removing the incontinence brief, NA-D began to cleanse R191's buttocks and upper back thighs. NA-D then began to pull a clean incontinence brief up between R191's legs when it was brought to NA-D's attention that R191's perineum had not been cleansed. NA-D did not comment, however, removed the pad and proceeded to provide total perineal care to R191.	F 312	performing diabetic nail care, incontinence care and assisting resident with dressing to maintain dignity. Measures put into place to prevent recurrence: Education was provided to staff on performing diabetic nail care, incontinence care and assist with dressing residents appropriately. Nurses responsible for nail care on 3/17/17 and 3/24/17 but failed to do so received coaching. Plan to monitor: RN Managers or designee will audit TAR's and/or inspect nails weekly x8 to ensure that diabetic nail care was done and take appropriate action in noncompliance is noted. A random audit of 2-3 resident per week x3 months will be conducted by the RN Managers or designee to observe incontinent cares and to ensure that residents are dressed appropriately. Responsible for maintaining compliance: RN Managers or designee and DON	

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R191's care plan, revised on 7/22/15, indicated R191 had functional bladder incontinence and was to be checked for urinary incontinence every two hours and provided incontinence hygiene.

The facility's policy dated 1/10 and titled Incontinent/Perineal Care, indicated for female residents perineal care was to start at the front of the perineal area, wash the meatus and labial areas and work outward to the surrounding perineum. Staff were to work from front to back to avoid contamination of the urethra.

The facility failed to ensure R214 was provided needed assistance in dressing.

R214's quarterly Minimum Data Set (MDS), dated 3/8/16 revealed R214 had both short and long term memory problems, severely impaired cognitive skills for decision making and was unable to recall basic information about living situation. R214 required extensive assistance of two or more staff to dress.

R214's Medication Review Report, dated 2/24/17, revealed diagnoses including Alzheimer's Disease with Early Onset and Anxiety Disorder, Unspecified.

R214's Care Plan, last revised, 3/20/17, directed staff "Dressing: requires extensive assist of up to 2 staff. Make consistent dressing/grooming routine to provide a structured program to decrease confusion. Wears camisole under shirt Q [every] day."

R214's Nursing Assistant Care Plan, updated 3/30/17, directed staff R214 required assistance of 1 staff for dressing. No notation was made

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F 312	Continued From page 22 regarding undergarments. On 3/29/17, at 7:34 a.m. R214 was observed lifting her shirt twice to wipe her mouth while sitting in the lounge area. R214's breasts were exposed when the shirt was lifted up. No undergarments were visible. Several other residents, staff and visitors were in the area. R214 was then taken by staff to the dining room. On 3/30/17, between 9:13 a.m. and 9:22 a.m. R214 was observed lifting shirt, exposing entire breasts, twice in the lounge area. No undergarments were visible. Multiple visitors, staff, and other residents were in the area. At 9:22 a.m., R214 propelled self using wheelchair to the hallway and exposed entire breasts, three times while lifting shirt to wipe mouth. Multiple staff, visitors, and other residents passed by in the hallway or were in nearby rooms. The dementia care manager led a tour group down the hallway past R214. R214 was noted licking her fingers and touching her clothes and objects in the hallway including the medication cart and hand rails. R214's pants and shirt had white soiled marks on them. At 9:28 a.m. RN-F walked into hallway and observed R214 exposing entire breasts when lifting shirt to wipe mouth . RN-F said "oh" in a surprised tone of voice and brought R214 to her room. RN-F first looked in R214's dresser drawers and then in the closet and found a clean shirt and undergarment to put on R214. NA-F entered the room and RN-F instructed NA-F that R214 should be dressed in an undergarment under her shirt every day. NA-F reported he could not find one when he dressed R214 earlier this morning and RN-F replied that one was found in the closet. NA-F reported being unaware R214 lifted her shirt.	F 312		

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F 312	Continued From page 23 On 3/30/17, at 10:31 a.m. the nurse manager, RN-G reported staff should speak to the nurse about any concerns related to not finding clothing to problem solve, look in laundry or ask a manager to help check in laundry. The Standards of Care Guidelines, revised 3/24/15, directed staff, "Woodbury Health Care Center staff will care for residents in a manner that promotes maintenance or enhancement of each resident's quality of life." and "Be sure undershirts, bras, slips, shorts or underwear are on appropriately."	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary	F 314	It is the policy of WHCC to provide all residents with the necessary care and	5/15/17

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F 314	Continued From page 24 treatment and services to minimize, prevent or promote healing of pressure ulcers for 3 of 4 residents (R123, R48, R191) in the sample with identified pressure ulcers. R123's pressure area was not adequately monitored per facility protocol and R123 was not provided positioning services to promote healing for 4 hours, resulting in harm. R48 had a new or recurrent pressure area that was not adequately assessed, resulting in harm. Findings include: R123 did not have a position change for four hours on 3/27/17, and had an unstageable pressure ulcer on the sacrum. On 3/27/17, at 7:00 p.m. nursing assistants (NA)-A and NA-B entered the resident's room, transferred R123 to bed and began to provide bedtime cares. During observation of the care, NA-A and NA-B expressed surprise upon seeing the pressure ulcer to R123's sacrum. At 7:15 p.m. NA-A and NA-B both verified during interview that neither had provided or offered care for R123 that shift until the bedtime cares. Both stated they thought R123 took care of self. In addition, NA-A and NA-B verified they did not know R123 had a pressure ulcer to the sacrum, but would call and inform the nurse. Document review of a facility form titled, Nursing Assistant Care Plan, updated 3/27/17, indicated R123 required assist of 2 staff for transfers and was to be repositioned every 2 hours. There was no mention that R123 had a pressure ulcer on the sacrum. Document review of a facility form titled Admission Record dated 3/29/17, indicated R123	F 314	services to minimize, prevent or promote healing of pressure ulcers unless unavoidable. Plan of correction for residents cited in this survey: R123, R48 and R191 have had a comprehensive skin assessment completed to re-evaluate their clinical condition and risk factors. Interventions that are consistent with R123, R48 and R191's needs, goals and recognized standards of practice have been defined and implemented using an interdisciplinary approach. Weekly monitoring and re-evaluation of the impact of the interventions is in place to ensure compliance. Plan to address/prevent this deficiency for other residents: As audit has been conducted to review and revise when needed the assessments, services and plans of care for all residents with pressure injuries or those at high risk for the development of alterations in skin integrity ensuring compliance. Measures put in place to prevent recurrence: All new or worsening pressure injuries will have a comprehensive skin and positioning evaluation completed. All residents with pressure injuries will be reviewed weekly by the RN Manager to monitor effectiveness of current plan/treatment.	

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F 314	Continued From page 25 had an initial admission date of 1/19/17. A document titled Progress Notes indicated R123 had been transported to the hospital on 3/1/17, at 11:34 a.m. and had been admitted for shortness of breath which turned into acute respiratory failure with hypoxia (oxygen deprivation). Progress Notes indicated on 3/16/17 at 11:40 a.m., R123 had been re-admitted to the facility. Review of R123's most recent cognitive assessment dated 3/29/17, indicated R123 had moderate cognitive impairment. A form titled Braden Scale for Predicting Pressure Sore Risk dated 3/29/17, indicated R123 had mild risk for developing pressure ulcers. Review of a hospital progress note for R123, dated 3/2/17 indicated: Pressure ulcer sacrum, Stage suspected deep tissue injury. Potential for impaired healing related to chronic respiratory failure and DM [diabetes mellitus] type 2. Length: 4.5 cm [centimeter] Width: 2 cm. wound bed 100% Agranular. Exudate: Yes, Serosanguineous small. Treatment plan: Silicone foam. A nursing home form titled Nursing Admission Screening History dated 3/16/17, indicated R123 had a wound on the coccyx; Length 3.5, Width 6, and Depth 0.8. There was no other documentation available regarding this wound. When the surveyor brought this to the attention of management, it was acknowledged that the facility failed to monitor and assess the wound from readmission until 3/29/17, at 2:06 p.m. A form titled Wound Assessment Details Report dated 3/29/17 indicated: wound: Sacrum Pressure ulceration Present on (re)admission unstageable Slough Loosely Adherent=100% size, 3.00 length, 1.5 Width, unknown depth and	F 314	Plan to monitor: The RN managers or designee will conduct wound rounds weekly to ensure compliance. The Comprehensive Skin and positioning evaluation will be completed for all new admissions, residents with new pressure injuries, upon significant change of condition and quarterly. All residents with current pressure injury will be reviewed monthly by the RN Managers and DON. Responsible for maintaining compliance: RN Managers or designee and DON.	

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the area is measured at 4.50 cm.

Review of R123's facility form titled, Daily Wound Monitoring was blank and had not been completed.

Document review of an undated facility policy Documenting Pressure Ulcers, directed weekly wound rounds and weekly wound documentation along with a comprehensive skin risk evaluation weekly. The policy further indicated that when an ulcer is present, daily monitoring with accompanying documentation using the Daily skin/wound monitoring sheet would be done.

When interviewed on 3/29/17, at 9:48 a.m. registered nurse (RN)-A and RN-B stated they were unaware of when R123's pressure ulcer had developed and did not know the staging but would evaluate, provide interventions and explained that R123 was in the re-admission assessment minimum data set (MDS) period. RN-A stated, "Staff should have followed the facility policies for daily wound monitoring."

When interviewed on 3/29/17 at 10:05 a.m., RN-D verified having documented on the Nursing Admission Screening History on 3/16/16, at 12:18 p.m. that R123 had a coccyx wound that was 3.5 length, 6 width, and 0.8 depth. RN-D verified the measurements were in centimeters, and that the pressure ulcer was a Stage 3.

During an interview on 3/29/17, at 2:00 p.m. licensed practical nurse (LPN)-B stated she had not been aware R123 had a sacral pressure ulcer until 3/27/17. LPN-B verified having documented, "Yes pressure ulcers" on 3/27/17 in the progress notes after having been informed of the pressure

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ulcer by NA-A and NA-B. LPN-B further verified no other assessment had been conducted or documented by her on 3/27/17 related to R123's pressure ulcer.

The facility's 9/2010 policy titled, Guidelines for Pressure Ulcer Prevention, indicated interventions for prevention and intervention of pressure ulcers were individually selected and holistic in approach. Revisions to the prevention plan were to occur when assessments were scheduled, when there was a change in condition, when a new risk factor became known or when an intervention was determined to be ineffective. The interventions were to be determined by an analysis of risk factors.

R48 was admitted to the facility on 11/30/16, with hospital discharge physician orders for Duoderm or similar to an open area on the coccyx. Although the resident had an order for Duoderm to an open area, the record lacked any documented assessment of the area until 1/6/17, to determine if the treatments ordered were appropriate to heal an identified pressure ulcer.

An 11/30/16, Nursing Admission Screening History document indicated R48 had a pressure ulcer on the coccyx, but no other assessment of the area was documented.

Physician's Order sheets indicated that on 12/5/16, Duoderm to the coccyx had been discontinued because the open area had resolved. A subsequent physician's order dated 12/17/16, indicated the physician had ordered a new treatment- wound cleanser, calcine, non-stick pad, and an Opsite dressing to the

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coccyx, indicating the open area had either re-opened, or a new pressure ulcer had developed.

A review of Progress Notes dated 12/5/16-1/5/17 revealed there had been no continued assessment of the resident's skin for maintained healing, or development of any new open areas on the coccyx. On 12/21/16, LPN-A documented R48 had a pressure ulcer that was being treated with non-surgical dressing change, ointments/cream/medications. However, there was no documentation found indicating the location or size of the open pressure ulcer.

A comprehensive pressure ulcer assessment of the open area on R48's coccyx was not completed until 1/6/17. According to a document titled Wound Summary dated 1/9/17, a Stage 3 pressure ulcer, measuring 3 centimeters (cm) long, by 1.5 cm wide and 0.60 cm deep, was noted on R48's coccyx.

On 3/28/17, at 12:42 p.m. RN-E stated she was unable to find anything in the "Wound Rounds" computer program regarding pressure ulcers at the time of R48's admission to the facility or prior to the assessment dated 1/6/17. On 3/30/17, RN-E again stated she was unable to find an admission comprehensive pressure ulcer assessment for R48. RN-E verified the Nursing Admission Screening History completed on 11/30/16, was not a complete assessment and did not include measurements of the pressure area on the resident's coccyx.

R191 was observed during wound care on 3/29/17, at 10:07 a.m. Licensed practical nurse (LPN)-A was observed to complete a dressing

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change to a pressure ulcer on R191's coccyx. During the observation an open area was noted on the back of R191's upper thigh, near the gluteal fold. At 10:09 a.m., LPN-A was interviewed and stated when she had observed the area on R191's thigh on 3/27/17 it had not been open. LPN-A then stated she would inform the unit's registered nurse about the open thigh wound. Nursing assistant (NA)-E, also present during the interview, stated the area on R191's thigh had been observed to be open on 3/28/17, and that information had been reported to a nurse that same date.

Following observation of the 3/29/17 dressing change, two staff assisted R191 to transfer to the wheelchair using a mechanical lift. At 11:15 a.m., R191 was observed sitting by the nursing offices. R191 remained in this area until 11:54 a.m. when she was taken outside to smoke.

At 12:26 p.m. on 3/29/17, R191 was observed back in her room. At that time R191 was interviewed and asked when she had last been repositioned. R191 stated she had not been repositioned since she'd gotten up after her dressing change earlier that morning. At 12:51 p.m. R191 received lunch in her room. At 1:04 p.m. a nursing assistant went into the room to speak with the resident however did not offer or provide repositioning for R191. At 1:11 p.m. a nursing assistant entered R191's room and removed the lunch tray, but R191 was not repositioned. At 1:25 p.m. R191 was transferred back into bed via the mechanical lift with assistance of two nursing assistants. At that point, R191 had not been positioned for approximately three hours since transferring into the wheelchair after the wound dressing change

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that morning.

R191 had been assessed by the facility on 12/29/16 to be cognitively intact.

During interview on 3/29/17, at 11:31 a.m. NA-E stated R191 was supposed to be turned and repositioned every two hours. However, an undated document titled Nursing Assistant Care Plan, directed staff to reposition R191 every hour. R191's care plan revised on 3/23/17, revealed there was a new skin breakdown on the left thigh and directed staff to turn and reposition R191 at least every hour or more often as requested.

A review of a Wound Summary document dated 3/23/17, indicated skin on the back of the left thigh was superficially excoriated and measured 3 centimeters (cm) by 1 cm, with no depth. There was no documentation found in the Wound Summary document, or in progress notes, to indicate a nurse had assessed the wound on 3/28/17 or on 3/29/17, despite NA-E and LPN-A stating they had reported the change in condition of R191's back left thigh.

On 3/31/17, at 8:42 a.m. registered nurse (RN)-D stated she was aware of the open area on the back of R191's thigh on 3/29/17, but had been too busy to assess the open area on 3/29/17. RN-D stated the area on the back of the left thigh at one time was thought to be excoriation, due to pulling an incontinent product up between R191's legs. However, at 8:52 a.m. RN-D stated she had determined on 3/30/17, the back of the left thigh was now a Stage 2 pressure ulcer measuring 4.5 cm by 1 cm, and was 0.2 cm in depth, which was a decline in skin condition from 3/23/17.

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F 315	Continued From page 31	F 315		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 315		5/15/17

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F 315	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 residents (R123 and R191) in the sample, who were identified as incontinent of urine, received the necessary care and services to manage incontinence. Findings include: R123 did not have an offer to toilet or to check for incontinence for over four hours on 3/27/17, and was incontinent of urine. During an observation on 3/27/17, from 3:00 p.m. until 7:00 p.m. R123 was observed in the bedroom in a wheelchair. At 6:37 p.m. licensed practical nurse (LPN)-B came to the room and was looking for gastrostomy tubing to begin the tube feeding. LPN-B left the room in search of supplies. On 3/27/17, at 7:00 p.m. nursing assistant (NA)-A and NA-B came into the room, positioned the wheel chair next to the bed and transferred R123 into the bed and began cares. R123 was incontinent of urine in the brief, moderate saturation. When interviewed during cares on 3/27/17, at 7:15 p.m. NA-A and NA-B verified neither had performed any cares or offered cares for R123 since coming on the evening shift, because they thought R123 took care of self. Furthermore, NA-A and NA-B verified no offers to toilet R123 were offered on their shift because they thought R123 was continent of urine. Document review of the form titled, Nursing Assistant Care Plan, updated 3/27/17, indicated	F 315	It is the policy at WHCC to provide services and assistance to maintain continence unless the residents clinical condition make it impossible. Plan of correction for residents cited with this survey: R123 and R191 had their plan of care updated to reflect the care and services provided to attain or maintain their highest level of practicable function. Nursing assistant care plans were updated to match the plan of care. Plan to address/prevent this deficiency for other residents: A comparison of the Nursing Assistant Care plan to the current plan of care was conducted for all incontinent residents to ensure compliance. revisions and updates were made as needed and communicated to staff. All new admits will have a temporary care plan within the first 24 hours of admission/readmission. Measure put into place to prevent recurrence: RN Managers will audit all new admission to ensure that a temporary care plan is in place and matches the Nursing Assistant Care Plan. Education was provided to staff on the necessary care and services to manager incontinence and on keeping care plans current. Plan to Monitor: The RN manager or designee will conduct	

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F 315	Continued From page 33 R123 required assist of 2 staff for transfers and to be repositioned every 2 hours. Document review of the 3/17/17, form titled, Individual Temporary Care Plan, indicated R123 required staff assist of 2 for transfers and re-positioning. Bowel and Bladder status read, Incontinent requiring staff assistance. When interviewed on 3/30/17, at 2:00 p.m. RN-A verified R123 was incontinent of urine and the staff should have offered toileting every 2 hours with position changes. R191's care plan revised on 7/22/15, revealed R191 had functional bladder incontinence and was to use a bed pan during Customer Service Rounds. The care plan directed staff to place R191 on a bedpan, for urinary incontinence at least every two hours. The care plan indicated R191 did not use the toilet per her preference. On 3/29/17, at 11:15 a.m., R191 was observed sitting in a wheelchair by the nursing offices. R191 remained in this area until 11:54 a.m. when taken outside to smoke. At 12:26 p.m. R191 was back on the unit and in her room where R191 remained until 1:21 p.m. when R191 was asked if she wanted to go to bed and R191 stated she would. At 1:25 p.m. (which was 2 hours and 10 minutes without being checked for urinary incontinence) R191 was transferred back into bed via a mechanical lift and the assistance of nursing assistants (NA) D and NA-E. NA-D and NA-E were observed to remove an incontinence brief, which was saturated with urine and provide peri-care. Instead of using a bed pan, NA-D and NA-E replaced the wet incontinent brief	F 315	weekly audits x3 moths observing 3-4 residents with incontinence to ensure incontinent cares and adherence to the current plan of care. Audit findings will be reviewed monthly at the QAPI meetings. Audits will continue if deemed necessary. Responsible for maintaining compliance: RN Managers or designee and DON	

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F 315	Continued From page 34 with a new brief. On 3/30/17, at 10:15 a.m. recreational therapist (RT)-A was asked if there was a bed pan in R191's room. RT-A searched R191's room and stated "I don't see one." Also at this time, R191, stated she was not using a bed pan. On 3/30/17, at 10:20 a.m. NA-G stated R191 did not use a bed pan and wore an incontinence brief.	F 315		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are	F 323		5/15/17

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F 323	Continued From page 35 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility did not complete an accurate and comprehensive smoking assessment regarding safety and did not provide a safe location for smoking for 1 of 1 resident (R50) in the sample observed smoking, and the facility did not provide handrails for safe ambulation in the hall near therapy services for residents who receive therapy services and ambulate in the hallway near the therapy services. Findings include: On 3/28/17 at 9:54 a.m. R50 was smoking with the supervision of nursing assistant (NA)-G in the outdoor designated smoking area for residents that was located immediately outside the lower level south exit of the facility. The facility's oxygen supplier was parked within 20 feet of this exit and actively filling oxygen tanks at that location. Immediately inside the door of this exit were 8 large oxygen tanks, temporarily stored until distributed to other areas of the building. The smoking area was furnished with two benches, two smokers' posts, and a sign on a building post that read, "Designated Smoking Area." The administrator and engineering director were touring near the exit with state fire marshal (FM)-D. When FM-D commented on the safety risk of the situation the administrator and engineering director assisted NA-G in moving the smoking residents farther away from the building. At 10:07 a.m. on the same date, this facility staff moved the benches and smoking posts out of this designated smoking area to another side of the	F 323	It is the policy of WHCC that each resident receives adequate supervision and assistance to prevent accidents. Plan of correction for the residents cited with this survey: Upon notification of this finding, R%) was immediately provided with a safe designated smoking location. No hard came to this or any other resident that smokes. Handrail installation was completed during the survey. No resident was unattended or without a gait belt at the time that the handrail was not in place. No hard to any resident resulted from the handrail not being present. Plan to address/prevent this deficiency with other residents: Upon notification of the finding, the designated smoking area was permanently moved with the location approved by the state fire Marshall who was on site. The handrails are in place so the risk is no longer present. Measures put into place to prevent recurrence: Designated smoking area was permanently moved. Should handrails be down in the future, the area will be closed to resident use. Plan to Monitor: Staff assist residents that smoke to the designated smoking area daily. Plant	

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F 323	Continued From page 36 building and removed the "Designated Smoking Area" sign. R50's record contained a Smoking Safety Screen form, dated 3/16/17, that showed R50 required supervision for smoking due to cognitive deficits and would "be unsafe to be consistent with decisions regarding smoking." This form also described the resident as smoking morning, afternoon, and evenings, taking 5-10 cigarettes per day. The safety risk of the facility's designated smoking area was not identified on this assessment. This resident's current care plan, dated 1/29/17, contained a Focus for smoking risk that included an interventions that read, "Staff are to escort [R50's name] to designated smoking area as time allows and supervise smoking/safety." On 3/28/17 at 9:55 a.m. NA-G was asked if the designated smoking area that she brought residents to smoke on that date was the area that she always brought residents to smoke, and she replied that it was. On 3/30/17 at 2:58 p.m. the facility's corporate consultant was asked where and why the designated smoking area had been relocated. She replied that the designated smoking area had been moved to another side of the building and had been moved because the fire marshal approached the facility administrator with concern regarding the proximity of the original designated smoking area to the facility's area for oxygen filling and delivery. The facility's smoking policy, dated 1/28/17, read, "All residents requesting to smoke will be assessed for independent and	F 323	operations Director will close any area without handrails to the residents until installed in the future. Responsible for maintaining compliance: Plant Operations Director and Administrator	

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F 323	Continued From page 37 supervised/assisted smoking status using the "Smoking Safety Screen" assessment form...Residents requiring supervision must agree to: ...c. smoking only in designated areas. d. scheduled smoking opportunities to be included in their care plan." On 3/27/17 and 3/28/17 residents participated in therapy services on the lower level of the facility. Renovation of the lower level was in progress and no handrails were present in the hallway containing therapy services. On 3/29/17 at 8:45 a.m. a construction crew was installing handrails in the hallway of the basement level that contained therapy services. During environmental tour on 3/31/17 at 9:15 a.m. the facility administrator stated that the contractor's plan regarding handrails had been to install the handrails after wallpapering was finished on the lower level. Wallpapering was completed on 3/24/17. The administrator also stated that residents had been using the hallway in the lower level for therapy services for roughly a week before survey. On 3/31/17 at 11:30 a.m. the director of nursing was asked how many residents who used therapy services the week of survey had ambulated in the hallway without handrails near therapy service. She replied that number was five, and added that these residents had walked with staff and a gait belt.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		5/15/17

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F 325	Continued From page 38 (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to provide nutritional interventions for 1 of 1 resident (R123) in the sample with weight loss, by ensuring the appropriate amount of tube feeding to prevent weight loss. Findings include: R123 lost 10.4 pounds of weight in thirteen days from 3/16/17, through 3/28/17, on gastrostomy/jejunostomy (G/J) tube feeding while at the facility. During an observation on 3/27/17, from 3:00 p.m. until 7:00 p.m. R123 was observed in the bedroom in a wheelchair with no food or fluids, and no tube feeding running. At 6:37 p.m. licensed practical nurse (LPN)-B came to the	F 325	It is the policy of WHCC that all residents maintain acceptable parameters of nutritional status unless unavoidable. Plan of Correction for resident cited with this survey: R123 was reassessed by the dietician to ensure nutritional needs are met and appropriate interventions are in place. Plan to address/prevent this deficiency with other residents: All residents receiving tube feeding were reviewed to ensure their nutritional needs were being met. Updates and revisions were made to the plan of care if warranted. Admissions has been educated on advance planning for those residents admitting on a tube feeding to	

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F 325	Continued From page 39 room and looked for gastrostomy tubing to begin the tube feeding. LPN-B left the room in search of supplies. On 3/27/17, at 7:00 p.m. nursing assistant (NA)-A and NA-B came into the room, positioned the wheel chair next to the bed, transferred R123 into the bed, and began cares. Document review of R123's form titled Admission Record, dated 3/29/17, indicated an initial admission date of 1/19/17, with a most recent hospital stay of 3/3/17, until 3/16/17. The document titled Progress Notes (PN) indicated R123 was transported to the hospital on 3/1/17, at 11:34 a.m. and admitted for shortness of breath which turned into acute respiratory failure with hypoxia (oxygen deprivation). On 3/16/17, at 11:40 a.m. R123 was re-admitted back to the facility. Document review of R123's most recent cognition assessment dated 3/29/17, indicated moderate impairment. Document review of the hospital discharge physician orders dated 3/16/17, and read, Diet tube feeding no tray NPO [nothing per mouth] feeding tube is a GJ [gastrostomy jejunostomy] placed 12/2016, 3/14 failed swallow eval, may alter to intermittent or nocturnal feeds. Tube feeding formula Replete with fiber Tube feeding continuous Goal Rate 75 ml/hr [millimeter per hour] Tube feeding flush 140 ml water every 8 hours split G and J port. The Goal Rate of 75 ml/hr of Replete with fiber would equal 1800 cc/day feeding, and the water 140 ml every 8 hours would equal 420 ml of water per day. This total fluid intake per day would equal 2220 milliliters.	F 325	ensure supplies are available before the resident arrives or that a 3 day supply has been requested of the hospital to send with the resident. Measure to put in place to prevent recurrence: Admissions staff received education on advance planning for residents admitting on tube feeding to ensure supplies are available before the resident arrives or to request 3 day supply from the hospital to be sent with the resident. Nurses were educated on immediate clarification of tube feeding orders and to notify the dietician of all new residents admitting with tube feeding order to ensure compliance. All dietician recommendations will do directly to the RN Manager to be processed. The nurses failing to document administration of tube feeding have been coached. Plan to Monitor: RN Manger or designee will audit all newly admitted residents that receive tube feeding within 24 hours to ensure compliance. Dietician will review all residents that receive tube feeding and make a note monthly or more often as indicated. Responsible for maintaining compliance: RN Manager or designee, Dietician and Admissions	

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F 325	Continued From page 40	F 325		

Document review of the hospital discharge physician order also read, amino acids-protein hydrolys 15-60 gram kcal/30 mL Lipk {sic} 1 packet (prosource No Carb) by Enteral Tube route 3 (three) times a day. Last dose given 3/8/17 8:03 a.m.. This order was not clarified with the physician and was transcribed on the treatment sheet as a give order. Document review of the treatment sheets indicated these amino acids were not given. The attending physician (AP) verified when interviewed on 3/29/17, at 12:36 p.m. that the facility should have informed AP about this order and there should have been a discussion since the hospital gave the order due to severe malnutrition.

Document review of the March 2017 form titled, Treatment Administration Record (TAR), indicated on 3/16/17, at 10:40 p.m. Tube feeding running at 75 ml/hr. Tolerated well. There was no tube feeding documented for the day shift or the night shift indicated on the TAR. R123 weighed 181.6 pounds on the admission weight.

Document review of TAR (treatment administration record) indicated on 3/17/17, nights missed the tube feeding and the PN (progress note) included: continue to pull on tube feeding cord and writer keep {sic} re-orienting patient. On 3/17/17, at 2:32 p.m. the PN read, Pt was uncooperative wonders {sic}and enter in resident room and will not keep feeding in place. At 6:08 p.m. the PN read, Refused to have tube feedings restarted. R123 was weighed at 180.6 pounds on 3/17/17.

Document review of the TAR indicated on 3/18/17, day shift did not sign out the tube feeding. R123 was weighed at 180.4 pounds.

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F 325	Continued From page 41 Document review of the TAR indicated on 3/19/17, evening shift did not sign out the tube feeding. R123 was weighed at 181.1 pounds. Document review of the TAR indicated on 3/20/17, evening shift did not sign out the tube feeding. R123 was weighed at 181 pounds. Document review of the TAR indicated on 3/21/17, R123 was weighed at 180.6 pounds. Document review of the TAR indicated on 3/22/17, R123 was weighed at 177.8 pounds. Evenings did not sign out the tube feeding on the TAR. Document review of the physician progress notes dated 3/22/17, read, "Malnutrition he is on tube feeding. He is having difficulty participating in therapy as he is hooked on tube feeding 24/7 so I am going to shift his regimen to overnight tube feeding from 6 p.m. to 8 a.m. in the morning with bolus feedings 3 times daily and continue with his water flushes dietary will assess. Will also monitor his weights to make sure he is not losing weight on his regimen." Under the Physician Orders document dated 3/22/17, read, Change TF [tube feeding] regimen to 80 ml (milliliter) / hr (per hour) from 6 PM to 8 AM. 120 ml bolus TF TID [three times per day] at breakfast, lunch and dinner. Continue water flushes. Dietary eval for pt. Document review of the Dietary Eval dated 3/22/17, read, *needs not met-Recommend increase TF to Replete with fiber 110 ml/hr from 6 p.m. to 8 a.m. change bolus to Jevity 1.5 BLD [breakfast, lunch, dinner] 3X/d [three times per	F 325		

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F 325	Continued From page 42 day]. Changing the Replete with fiber tube feeding order to 80 ml from 6:00 p.m. to 8:00 a.m. was 1480 milliliters, adding the 360 ml of bolus feeding gave R123 1480 ml or 320 ml less than originally prescribed since re-admitted 3/16/17. Document review of the physician orders revealed the physician was not informed of the dietary eval/recommendation until 3/27/17. Document review of the TAR indicated on 3/23/17, R123 received 120 ml bolus TID of Jevity 1.5 or 360 cc for the day and 80 ml /hr of Replete with fiber tube feeding from 6:00 p.m. to 8:00 a.m. to equal 1120 cc of feeding or 1480 cc's per day which is deficient 320 cc of tube feeding per day since 3/22/17. Document review of the TAR indicated on 3/23/17, R123 was weighed at 176.6 pounds. Document review of the TAR indicated on 3/24/17, R123 was weighed at 176 pounds. Document review of the TAR indicated on 3/25/17, R123 was weighed at 177 pounds. Document review of the TAR indicated on 3/26/17, R123 was weighed at 176.6 pounds. Document review of the TAR indicated on 3/27/17, R123 was weighed at 173.6 pounds. Document review of the TAR indicated on 3/28/17, R123 was weighed at 171.2 pounds. Document review of the TAR for tube feeding flush 140 cc water every 8 hours, split G and J port every 8 hours indicated no 140 ml water flush on nights 3/19/17, evenings of 3/22/17, 3/24/17, 3/26/17 and 3/27/17. Document review of the blood labs obtained 3/2/17 indicated a BUN	F 325		

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F 325	Continued From page 43 [Blood urea nitrogen] of 27 mg/dl. The normal BUN is 8-22 mg/dl and higher levels can be an indicator for kidney disease or dehydration. Document review of the BUN obtained 3/15/17, indicated 31 mg/dl. Document review of the BUN obtained 3/22/17 was 41 mg/dl. The creatinine levels remained within normal limits of 0.70-1.30 mg/dl. Document review of the form titled, Individual Temporary Care Plan, dated 3/17/17, addressed nutrition as a tube feeding, NPO. Hydration status/Fluid intake read Encourage which was inaccurate on the care plan because R123 was NPO per physician order dated 3/16/17. Document review of the undated policy titled, Gastrostomy: Tube Feeder-Hydration, directed, It is the policy that all tube feeders will receive minimum of 1800 cc of fluids per 24 hours. If the total is less than 1800 cc's, physician is notified of our policy. When interviewed on 3/30/17, at 2:00 p.m. the dietitian verified the physician should have been informed of the miscalculated calorie needs R123 required on 3/22/17, which could have prevented the most recent weight loss. Furthermore, the dietitian verified R123 was to be NPO. Document review of the assessment titled, Speech Therapy Plan of Care, dated 3/22/17, read, A swallow screening was completed, which revealed continued severe dysphagia due to swelling at the base of the epiglottis and posterior pharyngeal wall. He will remain on an NPO diet. Alternative method of feeding primary source of nutrition, hydration.	F 325		

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F 325	Continued From page 44 R123 was compromised with a pressure ulcer, and a surgical wound from amputation of left foot. This would indicate a greater nutritional need for wound healing.	F 325		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		5/15/17

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F 431	Continued From page 45 instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store and label medications properly for 8 of 31 residents (R92, R17, R23, R160, R247, R54, R323 and R318) reviewed for medication storage. In addition, the facility did not remove expired stock medications from medication storage, which had the potential to affect residents residing on the second floor unit, of the 131 residents who resided in the facility. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R92, R17, R23, R160, R247, R54, R323 and R318, which included ointment/cream, eye drops, and inhaler, lacked dates to indicate when they	F 431	It is the policy of WHCC to establish and maintain accurate labeling and dispensing of medications that have not expired. Plan of correction for residents cited with this survey: R92, R17, R23, R160, R247, R54, R323, and R318 had identified medications immediately discarded and replaced when identified during the survey and labeled correctly. Plan to address/prevent this deficiency for other residents: An audit of all resident medications was conducted to identify and correct any that have expired or require date when opened to ensure compliance. Those out of	

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F 431	Continued From page 46 were opened, or when the medications expired. On 3/27/17, at 1:00 p.m. the first floor west medication cart was observed to contain one bottle of Travatan eye drops for R323, which were not dated when opened. In the first floor south medication cart a bottle of Dorzol/Timol eye drops was observed to not be dated when opened for R318. Also in the medication cart, was a bottle of milk of magnesia (MOM) which had expired 1/17. At 1:10 p.m. a bottle of acetaminophen 325 milligrams, expired 12/16, was observed in the medication room. The expired acetaminophen was verified at the time with registered nurse (RN)-A. At 1:15 p.m. RN-A was asked what the facility's policy was regarding dating eye drops when opened. RN-A stated they had only been at the facility for a week and would find out what the policy was At 1:25 p.m., the east medication cart was observed to contain a bottle of MOM, which had expired on 2/17. RN-C verified the expiration date of the MOM. When interviewed, RN-C stated eye drops were to be dated when opened. During the medication storage tour on 3/30/17, at 9:17 a.m. with licensed practical nurse (LPN)-C, in the second floor treatment cart 2, multiple opened, used, undated, and expired medication tubes were stored in treatment carts. Observations included the following: R92's Triamcinolone Acetonide cream 0.025%	F 431	compliance were removed, discarded, replaced and properly labeled. Measures to put in place to prevent recurrence: The policy and procedure for medications that require date when open stickers or that have expired was reviewed and remains current. Nursing staff that pass medication were educated on the policy and procedure. Medication carts will be inspected weekly for expired medications, label issues and dates by the nurse. Plan to monitor: RN Manger or designee will conduct audits of 1 medication room and 1 medication care and 1 medication refrigerator monthly x3. Audit findings will be reviewed at QAPI meetings monthly. Audits will continue if needed. Responsible for maintaining compliance: RN Managers, medication passers, designee and DON.	

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F 431	Continued From page 47	F 431		

(for arthritis) ointment/cream tube was opened, used, undated and expired on 1/30/17 with refill date of 2/24/16.
R17's Proctozone cream -HC ointment/cream tube was opened, used, undated and expired on 12/9/16 with refill date of 12/10/15.
R23's Triamcinolone Acetonide cream 0.1% (for rash) ointment/cream tube was opened, used, undated and expired on 2/12/17 with refill date of 2/25/16.
R160's Triamcinolone Acetonide cream 0.1% ointment/cream tube was opened, used, undated and expired on 11/01/16 with refill date of 11/2/15.
Nyamyc powder bottle was opened, used and expired on 1/1/17. Desonide cream 0.05% ointment/cream tube was opened, used and expired on 12/9/16.

On 3/30/17, at 9:21 a.m. LPN-C verified the medications needed to be labeled and stored properly, and removed them from the treatment cart. LPN-C indicated, will reorder these medications as needed and explained the expectation was for staff to remove the expired medication from the treatment cart and put it in red discard bin in medication room.

During medication storage tour on 3/30/17, at 10:05 a.m. with trained medication aide (TMA)-A, the second floor cart 2 was reviewed. The following observation was made:
R247's Betimol solution 0.5% (anti-glaucoma) eye drop bottle was opened, used, and was undated, with refill date of 2/18/17.

On 3/30/17, at 10:07 a.m. TMA-A verified medications should be labeled and stored properly. TMA-A stated that eye drops were supposed to be dated when opened, and said

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would remove the eye drops from the medication cart and reorder them.

During an interview on 3/30/17, at 11:16 a.m. registered nurse (RN)-D hoped that staff knew they needed to date eye drop bottles when opened. RN-D removed the expired medications from the medication cart. RN-D added, "My expectation is that if staff see an expired medication or cream they should remove it."

During medication storage tour on 3/30/17, at 11:33 a.m. with RN-D, the second floor cart 1 was reviewed. The following observation was made: R54's Advair Diskus 500/50 (chronic obstructive pulmonary disease) inhaler was opened, used, and was undated.

On 3/30/17, at 11:35 a.m. RN-D verified medications should be labeled and stored properly. RN-D verified that the medication should have been dated, and had no idea when it was opened. RN-D said she would remove it from the medication cart and would check in the medication room to see if they had another one, if not would call the pharmacy to get another one as soon as possible.

On 3/30/17, at 11:43 a.m. the director of nursing (DON) explained that staff were supposed to date medication bottles, creams, and vials when opened; check for expired medications; and remove expired medications from supply areas. The DON added that staff should follow policies and recommendations, and if medication is beyond the recommendation date, medications should be destroyed per facility policy and procedure. It is an assigned duty for the weekend nursing staff to check the medication carts for

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F 431	Continued From page 49 expired medications. In addition, the DON mentioned the Merwin's pharmacy consultant was in the facility on Monday, and looked through all the medication carts. Medication storage and expiration guidelines dated 8/2015, directed, "ADVAIR Discus Room Temp 30 Days After 1st Use, DATE WHEN OPEN Yes. Timolol Maleate Room Temp 1 month after opened DATE WHEN OPEN Yes. Topical agent Unspecified Topical Agents Room temp Manufacturer's labeled date". Policy and procedure titled, MEDICATION STORAGE IN THE FACILITY, dated 12/07/16, read, "10. Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, unlabeled or without secure closures are immediately removed from stock, disposed of according to facility procedures for medication destruction and reordered from the pharmacy if a current order exists."	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 441		5/15/17

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F 441	Continued From page 50 accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 441		

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F 441	Continued From page 51 (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection during cares for 3 of 5 residents (R191, R215, R318) observed during cares. Findings include: During observation of wound and incontinence care for R191, staff were not observed to change gloves and wash hands. On 3/29/17, at 9:59 a.m. licensed practical nurse (LPN)-A was observed to wash hands before donning gloves and beginning a colostomy bag change for R191. LPN-A removed the colostomy bag, and without removing gloves, began cleansing the skin around the stoma and a fistula on the bottom of the stoma with disposable wipes. Stool was noted on the wipes during the cleansing, and without changing gloves, LPN-A put a premapour dressing over the fistula. Then with same soiled gloves, LPN-A put on stoma ring adhesive around the stoma, and then a new bag.	F 441	It is the policy of WHCC to establish and maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Plan of correction for residents cited in this survey: R191, R215, and R318 had their medical condition reviewed and remain infection free as a result of this practice. Plan to address/prevent this deficiency for other residents: All staff assisting with ADLs or performing wound/ostomy care attended hand hygiene in-services which included glove technique. Measures put in place to prevent recurrence: The policy and procedure for hand hygiene and glove technique have been reviewed and remain current. All staff assisting with ADLs or performing	

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F 441	Continued From page 52 At 10:05 a.m. LPN-A removed the gloves and washed hands before putting on a new pair of gloves and beginning dressing changes for open areas on R191's skin. LPN-A took a disposable wipe and cleansed an open area on R191's upper back left thigh. Wearing the same gloves, LPN-A took a new disposable wipe and cleansed an open area on R191's coccyx. Then wearing the same gloves, LPN-A soaked a calcium alginate dressing in saline and applied it to the coccyx wound. Still wearing the same gloves, LPN-A applied an island dressing to the coccyx wound. Still wearing the same gloves, LPN-A soaked a gauze pad in normal saline and cleansed the left back thigh wound. Still wearing the same gloves, LPN-A applied A&D ointment to the left thigh wound. Still wearing the same gloves, LPN-A put an incontinent brief underneath the resident and assisted nursing assistant (NA)-E with turning R191 to the side to get the rest of the pad beneath the resident. On 3/29/17, at 1:25 p.m. incontinent care was provided to R191. NA-D was observed to wash hands and don gloves prior to beginning cares. R191's incontinent pad was noted to be saturated with urine, and after removing the incontinent brief NA-D began to cleanse R191's buttocks and upper back thighs. Without removing gloves and washing hands, NA-D applied A&D ointment to an open area on R191's upper back left thigh and then began to pull a clean incontinent brief up between R191's legs. During an observation on 3/27/17, at 4:27 p.m. trained medication aide (TMA)-A went into the bathroom (BR) of R215 to don a pair of gloves without hand washing, and obtained a blood	F 441	wound/ostomy care received re-education on the policy and procedure. Plan to monitor: The RN Managers or designee will conduct random audits weekly x3 months observing glove use and hand hygiene during ADLs and wound/ostomy cares. Audit findings will be reviewed monthly at the QAPI meeting. Audits will continue if deemed necessary. Responsible for maintaining compliance: RN Managers or deisngee, infection control nurse and DON.	

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sample for a blood glucose. TMA-A adjusted the overflowing trash, put in a new trash bag, removed gloves, went into the BR and washed hands for 8 seconds. Then TMA-A picked up the soiled trash bag and left the room.

When interviewed on 3/27/17, at 4:30 p.m. regarding hand washing, TMA-A did not know how many seconds hands should be washed, and did not know how many seconds TMA-A performed the handwashing after the glucometer procedure.

During an observation on 3/29/17, at 8:26 a.m. registered nurse (RN)-D came into R318's room to administer medication in a gastrostomy tube. RN-D washed hands for 10 seconds, turned the hot and cold faucet handles off with wet hands, and then dried hands with paper towels and donned gloves to perform a gastrostomy tube flush. RN-D flushed the tubing with water and continued to wear the same contaminated gloves to change the gastrostomy site dressing on the abdomen. After the treatment, RN-D washed hands under running water for 10 seconds and again turned off the water faucets with both hands before obtaining paper towels to dry hands.

When interviewed on 3/29/17, at 8:40 a.m. RN-D verified paper towels should have been used to turn off the water and that handwashing should have been for 20 seconds, but RN-D verified failed to count the time when handwashing.

Document review of the 8/6/12 policy titled Handwashing directed to use friction, rub hands together, cleaning under nails and between fingers thoroughly. Wash up to wrists. Do this for

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F 441	Continued From page 54 20 seconds at a minimum. When finished, turn off the faucet with a clean paper towel and discard the towel in an appropriate trash container. Document review of the facility's 1/11 revised policy titled Glove Techniques (non-sterile) indicated staff were to wear clean non-sterile gloves when touching blood, body fluids, secretions, excretions or other potentially infectious materials and contaminated items. The policy directed staff to change gloves between tasks and procedures on the same resident after contact with material that may contain a high-concentration of microorganisms.	F 441		

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

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

Electronically Signed | 04/28/2017

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Woodbury Healthcare Center is a 4-story building with no basement. The building was constructed at 2 different times. The original 3 story building was constructed in 1979 and was determined to be of Type II(222) construction. In 1986, a fourth floor addition was constructed that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 175 beds and had a census of 158 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is within 3 feet and adequate to	K 000		

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K 000	Continued From page 2 provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 741 SS=E	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility and staff failed to adhere to NFPA 101	K 741	The preparation of the following plan of correction for this deficiency does not	3/28/17

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K 741	Continued From page 3 LSC 2012 edition Ch. 19, section 19.7.4* Smoking regulations shall be adopted and shall include not less than the provisions within this chapter. Findings include: On a facility tour between the hours of 0830 and 1330 on 28 March 2017, observation revealed that the facility and staff failed to recongnize that the smoking area was at the same door and area that oxygen was being tranfilled. This deficient practice was verified by the Director of Maintenance and Administrator at the time of discovery.	K 741	constitute and should not be interpreted as an admission nor agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. On March 28, 2017 facility maintenance staff relocated the resident smoking area from the location where oxygen is trans filled and or transported to an open are 22ft.from the North of the building with approval from the fire Marshall. 2. Date of completion 03/28/2017. 3. Safety committee will monitor the designated smoking area monthly x3 to assure residents are smoking in the designated smoking area and are supervised by staff.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 920	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not use power cords and extension cords in a manner that exercises general precautions. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA99), 400.8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5. This deficient practice could affect all residents within the room. Findings include: On a facility tour between the hours of 0830 and 1330 on 28 March 2017, observation revealed that there were daisy chained power-strips in Room 215. This deficient practice was verified by the Director of Maintenance at the time of discovery.

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The above isolated deficiencies pose no actual harm to the residents