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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7BM9

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

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

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/14/2018** (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 **79** (L18)

13.Total Certified Beds **79** (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
	79			
(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, Health Laboratory Surveyor — 06/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Michaelyn Bruer, Enforcement Specialist — 06/11/2018 (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)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245320

June 8, 2018

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

Dear Ms. Jenkins:

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

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

Effective May 8, 2018 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 79 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 8, 2018

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

RE: Project Numbers S5320029 and H5320048

Dear Ms. Jenkins:

On April 14, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 29, 2018 that included an investigation of complaint number H5320048. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 14, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 8, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 29, 2018, effective May 8, 2018 and therefore remedies outlined in our letter to you dated April 14, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7BM9

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Facility ID: 00829

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(L4) **2060 UPPER 55TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/29/2018** (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) :

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___1. Acceptable POC
X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(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, Health Laboratory Supervisor 04/17/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 05/09/2018 (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)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1730 0001 7737 0298
April 14, 2018

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

RE: Project Numbers S5320029, H5320046, H5320047, H5320048

Dear Ms. Jenkins:

On March 29, 2018, 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. In addition, at the time of the March 29, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5320048 that was found to be substantiated. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required. In addition, at the time of the March 29, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5320046 and H5320047 that were found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 8, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 29, 2018 (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 September 29, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 03/29/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was conducted on 3/26 through 3/29, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 3/26 through 3/29, 2018 and complaint investigations were also completed at the time of the standard survey. At the time of the survey, an investigation of complaints #H5320046 and #H5320047 were completed and found to be unsubstantiated. An investigation of complaint #H5320048 was completed and was found to be substantiated at F578. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED APR 27 2018 HEALTH REGULATION DIVISION LICENSING AND CERTIFICATION 4/30/18 SER	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		

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

Executive Director 4-25-18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 03/29/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 1 to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced	F 578	F578 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. A physician order was obtained to coincide with the resident's wishes according to the signed advanced directive. Resident # 367 has since discharged from the facility. 2. All current resident advanced directives have been reviewed to assure the resident's wishes have a physician order that coincides. The advanced directive will be reviewed with the resident or resident representative quarterly with care conferences, or with changes in condition.	5/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 03/29/2018

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

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F 578	Continued From page 2 by: Based on document review and interview, the facility failed to correctly identify a full code status with the physician orders for 1 of 1 resident (R367) reviewed for cardiopulmonary resuscitation (CPR) status whose physician order did not match the plan of care or the directive to define the scope of medical care for full cardiac resuscitation. Findings include: Document review of R367's physician order dated 3/20/18, upon re-admission from the hospital directed DNR (do not resuscitate status). Document review of the form titled, Directives to Define Scope of Medical Care, read, "To resuscitate: Full cardiopulmonary resuscitation (CPR: forces respiration by external means, e.g. (example) mouth to mouth breathing; closed chest compressions." R367 signed the directives to define scope of medical care form on 3/20/18, and the nurse practitioner (NP) signed the same form on 3/21/18, but the NP failed to update the physician order to reflect R367 wished for full cardiopulmonary resuscitation and to negate the current do not resuscitate physician order. R367's plan of care dated, revision on 3/17/14 read, Code Status: CPR (Full Code) Advanced directive is on file. When interviewed on 3/28/18, at 9:00 a.m. registered nurse (RN)-A verified R367 signed the Directives to Define Scope of Medical Care, "To resuscitate: Full cardiopulmonary resuscitation." and the physician order should have been obtained at the same time to reflect the resident	F 578	3. All licensed staff will complete education regarding the advanced directive and honoring resident choices by 5/8/2018. 4. The Director of Nursing and/or designee will complete advanced directive audits twice weekly for one month and then once weekly for two months with focus on new admissions, hospital returns and residents with changes in condition. 5. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/re-commendation regarding any necessary follow-up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 03/29/2018

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F 578	Continued From page 3 wishes. When interviewed on 3/28/18, at 10:00 a.m. licensed practical nurse (LPN)-A verified the physician order should match the resident directive for CPR and R367 did not have a current physician order for full code status. When interviewed on 3/28/18, at 10:15 a.m. LPN-B verified the physician order was to match the resident directive for CPR and R367's did not match. Document review of the facility policy dated Sept. 2015 and titled Advanced Care planning and Provider Orders for Life Sustaining Treatment, directed, "A signed physician order denoting the resident's choice of status: DNR or Full Code, is required in all medical records."	F 578		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		

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F 657	Continued From page 4 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 document review, interview, and observation, the facility failed to review and revise the care plan with individualized interventions regarding medication administration for 1 of 2 residents (R34) reviewed for participation in care planning, and the facility failed to review and revise the care plan with interventions to reduce risk of medication side effects for 1 of 5 residents (R34) reviewed for unnecessary medication. Findings include: R34's Admission Record printed 3/29/18, indicated R34 was admitted on 8/18/16. The medical record revealed R34's diagnosis included macular degeneration with blindness, major depression, anxiety, hypertension, congestive heart failure, diabetes mellitus and dry eye syndrome. R34's physician order indicated R34 had orders for Coumadin 2 mg (milligram), Aspirin 81 mg, Lasix 60 mg, Duloxetine 20 mg, and Risperidone 0.25 mg. R34's quarterly Minimum Data Set (MDS) dated	F 657	F657 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. With respect to resident # 34, the care plan was revised to include person centered information for medication passes and including side effect monitoring for specific medications as well las risks associated with the medications in use. 2. All current residents receiving anticoagulant therapies and psychoactive medications had care plan reviews to assure individualization for medications and interventions associated with risks.	5/8/18

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F 657	Continued From page 5 2/17/18, revealed R34's brief interview for mental status (BIMS) score of 13 that indicated R34 was cognitively intact. The MDS also indicated R34 had received anticoagulant medication 7 times during the 7 day look back. On 3/26/18 at 6:53 p.m., R34 stated, "staff do not explain the medication they gave me, they just put the medication in a cup and ask me to open my mouth and dump it in my mouth. I like to know what I am taking. I used to be a nurse." On 3/28/18 at 9:16 a.m., observed trained medication aide (TMA)-A went to R34's room with medications, included Aspirin, Bisacodyl, Lasix, Duloxetine, Famotidine, Potassium chloride, Risperidone, Multiple Vitamins-Minerals, Coreg, etc. in a medication cup. TMA-A started administering medications without letting R34 know what medications [R34] was receiving. After multiple medications administered, R34 asked TMA-A if [R34] received Lasix yet and TMA-A responded, "Yes". On 3/28/18 at 9:30 a.m., TMA-A verified failing to explain to R34 what medication R34 was receiving and stated, she explained to R34 when R34 asked about Lasix. After review of R34's medical record on 3/28/18 at 9:40 a.m., R34's medical record that included medication administration record/treatment administration record (MAR/TAR) and care plan lacked documentation that included R34's wish for staff to explain what medication they were about to administer. On 3/28/18 at 9:44 a.m., the director of nursing	F 657	3. All licensed and trained medication staff will complete education regarding standard practice for med passes to include explanation of medications prior to administration, care planning and observation for medication side effects by 5/8/2018. 4. The Director of Nursing and/or designee will complete two care plan audits each week for one month and then one care plan audit each week for two months to assure the care plan is revised to include individualized care and intervention for monitoring medication risks. The Director of Nursing and/or designee will audit one med pass weekly for one month and then one med pass every other week for two months to assure medication passes include explanation of meds being administered.	

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F 657	Continued From page 6 (DON) stated the expectation was that staff tell residents what medication they were taking as it is part of their care. At 2:45 p.m., DON indicated, the care plan was updated to reflect R34's wishes. The updated care plan dated 3/28/18, directed staff to tell R34 what medications were being given at each medication pass. On 3/28/18 at 11:15 a.m., R34 verbalized staff did not explain what medications were administered, and hoped that she wouldn't have to ask every time what medication she was getting, especially the Lasix. In addition, R34 stated, "I am legally blind and I cannot see things and it should be their job to tell me what they are giving me. This is what happened this morning when she gave me my medication, she did not tell me what she was giving me and I had to ask her about my Lasix." On 3/29/18 at 12:37 p.m., R34 described being legally blind and said the only thing [R34] could see when looking at something, was an overall image, but could not describe what the image entailed. In addition, R34 wanted to be involved in the care planning such as what medications were given during the medication administration. R34 indicated this was very important to her. R34's care plan dated 8/25/17, indicated that R34 received psychotropic medications such as antipsychotics and antidepressants with goals and interventions. However, the care plan lacked documentation that R34 received Coumadin (anticoagulant). The medical record such as MAR/TAR and care plan lacked anticoagulant side effects monitoring for risk factors of medication.	F 657	5. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time the committee will make the decision/re-commendation regarding any necessary follow-up studies.	

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F 657	Continued From page 7 On 3/29/18 at 11:36 a.m., registered nurse (RN)-A confirmed, R34's care plan lacked documentation that R34 had orders for and received Coumadin (anticoagulant). In addition, verified R34's MAR/TAR lacked documentation for side effects monitoring of anticoagulant. RN-A stated, her expectation was the MDS coordinator should care plan that the resident was currently receiving an anticoagulant and what side effects should be monitored. On 3/29/18 at 1:00 p.m., RN-B verified, R34's care plan lacked documentation of the anticoagulant medication and said usually that was in the cardiovascular area of the care plan. RN-B further stated, it was not on [R34]'s most recent care plan and [R34] had been on an anticoagulant since 1/17/18. The facility policy and procedure titled PERSON CENTERED CARE PLAN GUIDELINE revised 11-2016, directed, "person-centered care planning focuses on the resident as the locus of control and supports the resident in making their own choices and having control over their daily lives." The policy further directed, "4. The overall person centered care plan should be orientated towards ... (ii) Managing risk factors ... (iv) Respecting the resident's personal preferences, cultural preferences and right to decline treatment".	F 657		

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Woodlyn Heights Healthcare 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: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	RECEIVED APR 27 2018 HEALTH REGULATION DIVISION LICENSING AND CERTIFICATION	

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

Executive Director 4-25-18

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 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Woodlyn Heights Healthcare Center is a 2-story building with no basement. The building was built in 1973 and was determined to be of Type II(111) construction. In 2014 a single story addition was added to the East and was determined to be of Type II(111) construction. The building is fully fire sprinklered. and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 79 beds and had a census of 63 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101	K 311		

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K 311	Continued From page 2 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.1.1 through 19.3.1.6) This deficient practice could affect the safety of all (4) the residents, staff and visitors within the smoke compartment in the lower level of the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 3/29/18, observations and staff interview revealed the following: CEILING PENETRATIONS FOUND MISSING PROPER FIRE CALKING / SEALANT - LAUNDRY OFFICE This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 311	K311 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Woodlyn Heights will ensure that the facility is in compliance with NFPA 101, Life Safety Code Standard. 1. The facility tour on 3/29/18 revealed ceiling penetrations with missing proper fire caulking/sealant in the laundry office. 2. Corrective action was taken to fill the identified penetration with the appropriate fire caulking on 4/20/18. 3. The Maintenance Director and/or designee is responsible for the corrective action and monitoring.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351		

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K 351	Continued From page 3 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (15) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 3/29/18, observations and staff interview revealed the following: 1. SUPPLIES IN STORAGE ROOM STACKED WITHIN THE 18 INCH MINIMUM CLEARANCE TO SPRINKLER HEAD 2. CABLING ATTACHED TO SPRINKLER SYSTEM PIPING - STARTING IN STORAGE ROOM ADJACENT TO DRY GOODS STORAGE AND CONTINUING TO MEDICAL RECORDS STORAGE ROOM	K 351	K351 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Woodlyn Heights will ensure to be in compliance with NFPA 13, Standard for Installation of Sprinkler Systems Life Safety Code Standard. 1. The facility tour on 3/29/18 revealed supplies in the storage room stacked within the 18 inch minimum clearance to sprinkler head, and cabling attached to sprinkler system piping – starting in storage room adjacent to dry goods storage and continuing to medical records storage room. 2. Corrective action was taken on 3/30/18 to remove the upper shelf of the storage unit to mitigate any supplies from being stacked within the minimum clearance of the identified sprinkler head.	

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K 351	Continued From page 4 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351	3. Corrective action was taken on 4/20/18 to remove all identified cabling secured to the sprinkler piping.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363	4. The Maintenance Director and/or designee is responsible for the corrective action and monitoring. K363 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Woodlyn Heights will ensure that the facility is in compliance with NFPA 101, Corridor Doors – Life Safety Code Standard. 1. The facility tour on 3/29/18 revealed that the smoke barrier door with latching mechanism did not latch properly on the 400 wing.	

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K 363	Continued From page 5 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.6.3,) This deficient practice could affect the safety of all (015) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 3/29/2018, observations and staff interview revealed the following: SMOKE BARRIER DOOR WITH LATCHING MECHANISM DID NOT LATCH PROPERLY - WING 400 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363	2. Corrective action has been taken to have a contractor assess the doors and provide estimate for replacement doors on 4/20/18. Due to having to special order the doors through the contractor and schedule the installation we will have a date certain of 5/25/18. 3. The Maintenance Director and/or designee is responsible for the corrective action and monitoring.	
K 751 SS=D	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	K 751	K751 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/29/2018**

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K 751	Continued From page 6 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.7.5.1, 19.3.5.11, 10.3.1) This deficient practice could affect the safety of all (4) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 3/29/2018, observations and staff interview revealed the following: SPA ROOM 400 - CEILING TRACKED PRIVACY CURTIAN IS POSITIONED IN CLOSE PROXCIMITY TO CEILING FIXTURE HAVING HEATING BULB. FIXTURE HAS 60 MIN TIMER. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 751	Woodlyn Heights will ensure that the facility is in compliance with NFPA 101, Draperies, Curtains, and Loosely Hanging Fabrics – Life Safety Code Standard. 1. The facility tour on 3/29/18 revealed a ceiling tracked privacy curtain positioned in close proximity to ceiling fixture having heating bulb with a 60 minute timer. 2. Corrective action was taken immediately by removing the identified privacy curtain on 3/29/18. 3. The Maintenance Director and/or designee is responsible for the corrective action and monitoring.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (Chapter 6 (NFPA 99)) This deficient practice could affect the safety of all (30) the residents, staff and visitors within the smoke compartments. Findings Include:	K 911	K911 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:	

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K 911	Continued From page 7 On facility tour between 09:00 AM and 01:00 PM on 3/29/2018, observations and staff interview revealed the following: UNLOCKED UTILITY PANELS IN RESIDENT CORRIDORS (ELECTRICAL CIRCUIT BREAKERS AND TELEPHONE PUNCH-DOWN) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 911	Woodlyn Heights will ensure that the facility is in compliance with NFPA 101, Life Safety Code, NFPA 99 Chapter 6, Electrical Systems Life Safety Code Standard. 1. The facility tour on 3/29/18 revealed unlocked utility panels in residents corridors (electrical circuit breakers and telephone punch-down).	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 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	K 920	2. Corrective action has been taken and new panel locks have been ordered for each identified panel 4/25/18. Date certain of 5/8/18. 3. The Maintenance Director and/or designee is responsible for the corrective action and monitoring. K920 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 920	Continued From page 8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) This deficient practice could affect the safety of all (2) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 3/29/2018, observations and staff interview revealed the following: NON-APPROVED POWER STRIP FOUND IN RESIDENT ROOM 414 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	Woodlyn Heights will ensure that the facility is in compliance with NFPA 101, Electrical Equipment – Power Cords and Extension Cords Life Safety Code Standard. 1. The facility tour on 3/29/18 revealed one non-approved power strip located in one resident room. 2. Corrective action was taken by removing the non-approved power strip from the resident room and replaced with one that meets the standard on 3/30/18. 3. The Maintenance Director and/or designee is responsible for the corrective action and monitoring.	